Filing at a Glance

Company:	Symetra Life Insurance Company
Product Name:	Select Benefits Critical Illness Policy
State:	District of Columbia
TOI:	H07I Individual Health - Specified Disease - Limited Benefit
Sub-TOI:	H07I.001 Critical Illness
Filing Type:	Form
Date Submitted:	09/04/2015
SERFF Tr Num:	FRCS-130232387
SERFF Status:	Submitted to State
State Tr Num:	
State Status:	
Co Tr Num:	6380
Implementation Date Requested:	On Approval
Author(s):	Michael Cochran, Marilyn Odell, Claire Miller, Janet Cardwell, Jackie McFall
Reviewer(s):	
Disposition Date:	
Disposition Status:	
Implementation Date:	

General Information

Project Name: Symetra/65
Project Number: 6380
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: Resubmission
Individual Market Type:
Filing Status Changed: 09/04/2015
State Status Changed:
Created By: Jackie McFall
Corresponding Filing Tracking Number:

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 01/26/2015
Domicile Status Comments:
Market Type: Individual
Previous Filing Number: SYMT-130137436
Overall Rate Impact:

Deemer Date:
Submitted By: Michael Cochran

Filing Description:
Re:Symetra Life Insurance Company
FEIN # 91-0742147;
NAIC # 68608
Select Benefits Critical Illness Policy

Forms
SBC-00500 8/12 Policy Form
SBC–00535–CERT/DC 04/14Certificate Form
SBC–00535–SCH 04/14 Certificate Form
SBC–00535–DEF/DC 04/14 Certificate Form
SBC–00535–ELI 04/14 Certificate Form
SBC–00535–BEN 04/14 Certificate Form
SBC–00535–EXC/DC 04/14 Certificate Form
SBC–00535–GEN/DC 04/14 Certificate Form
SBC–00991–GPA/DC 8/12Participation Agreement
SBC–00531–EOI 3/14 Enrollment/Evidence of Insurability

This is a resubmission of SYMT-130137436.

We are submitting the forms on behalf of Symetra Life Insurance Company.

The company requests that these forms become effective upon approval. The above captioned certificate insert pages, when combined together, will form an entire certificate providing Critical Illness Insurance. They will be incorporated into and made part of the policy also being filed.

Policy form SBC-00500 8/12 is a basic master policy that will be used with the certificate being filed here and other certificates that will be filed in the future.

These form do not deviate from generally accepted standard insurance practices. We’ve enclosed statements of variability on the Supporting Documents tab. The forms on the Forms tab are tagged with numbers matched to entries on the Statements of Variability on the Supporting Documents tab that explains the variable language that may be used for these forms.

The ancillary forms listed above will be used with this certificate are also enclosed.

The Participation Agreement will also be used with our previously approved Select Benefits Indemnity form LGC-8786/DC 02/03 series, LGC-9072/DC 11/05 series, Select Benefits Group Outpatient Prescription Drug LGC-10018/DC series, Select Benefits Critical Illness LGC-9095 02/07, SBC-00991-APP/DC 8/12, SBC-00992-ETR 01/13 series and SBC-00993-AMD 01/13.

These forms are filed and approved in the state of Iowa (the company's domiciliary state).

The actuarial memorandum and rates were approved on 5/26/15 under SERFF# SYMT-130022306.

This product will be marketed through agents and brokers to groups traditionally regarded as eligible for group accident insurance coverage. Most group policies will be issued to employer policyholders to cover their employees.

In addition, there was an outstanding objection for the previous SERFF filing. The Department's previous objection was, "Although some of your benefits offers lump sum pay outs, others do not. In addition you offer multiple benefits. Therefore, the mandated emergency services and ambulance benefits apply." Respectfully, the company requests the department's reconsideration of this objection. All benefits payable by the coverage are payable only in a lump sum benefit. The policy pays a lump sum percentage of the face amount for each of the benefits. This is a traditional method for Critical Illness Benefits. In addition, the department has indicated in the past that if the coverage pays in a lump sum benefit, the managed emergency services and ambulance benefits do not apply.

Additionally, the company revised the limited benefit disclosure on the page 1 of the policy. The policy has also been updated to remove language from the Conformity with Law provision which previously read, "unless otherwise forbidden by the laws of the state where the Certificateholder resides." The Reinstatement provision was also updated to include the sentence: "Policy will be reinstated lacking such approval, upon the 45TH day following the date of conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application."

The Certificate has been updated so that the Limited Benefit disclosure on the first page is in a larger font size as required by Bulletin 01-1B-007-02/08. The Dependent definition has been updated to include the language that "Your niece, nephew, or grandchild who You provide regular and primary care during the time that District of Columbia public schools are in session who are unmarried and under the age of 19" will be covered under the coverage as required under DC Ins Code 31-4712 (b)(J). The Pre-Existing Condition Limitation has been revised so that the timeframe required is 6 months. This complies with the requirement under 31-3303.07. The Notice of Claim & Claim Forms provisions have also been updated due to previous objections. The Time Payment of Claims provision has been updated to comply with DC Insurance Code 31-4712 (c)(H).

Thank you for your consideration of this filing.

Company and Contact

Filing Contact Information

Jackie McFall, Senior Compliance Specialist
1020 Central Ave, Suite 201
Kansas City, MO 64105

jackie.mcfall@firstconsulting.com
800-927-2730 [Phone]

State: *District of Columbia* ***Filing Company:*** *Symetra Life Insurance Company*
TOI/Sub-TOI: *H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*
Product Name: *Select Benefits Critical Illness Policy*
Project Name/Number: *Symetra/65/6380*

Filing Company Information

(This filing was made by a third party - FC01)

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
(414) 977-1501 ext. [Phone]

CoCode: 68608
Group Code: 1129
Group Name: White Mountains Grp
FEIN Number: 91-0742147

State of Domicile: Iowa
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*FRCS-130232387*	***State Tracking #:***		***Company Tracking #:***	*6380*

State:	*District of Columbia*	***Filing Company:***	*Symetra Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Select Benefits Critical Illness Policy*		
Project Name/Number:	*Symetra/65/6380*		

Form Schedule

Lead Form Number: SBC-0500 8/12

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Fixed Payment Indemnity Certificate	SBC–00500 /DC 8/12	POL	Initial			SBC-00500-Policy-DC-8-12.pdf
2		Certificate of Coverage	SBC–00535 –CERT/DC 04/14	CER	Initial			SBC-00535-CERT-DC 04-14.pdf
3		Schedule of Benefits	SBC–00535 –SCH 04/14	MTX	Initial			SBC-00535-SCH 04-14.pdf
4		Definitions	SBC–00535 –DEF/DC 04/14	MTX	Initial			SBC-00535-DEF-DC 04-14.pdf
5		General Provisions	SBC–00535 –GEN/DC 04/14	MTX	Initial			SBC-00535-GEN-DC- 04-14.pdf
6		Exclusions and Limitations	SBC–00535 –EXC/DC 04/14	MTX	Initial			SBC-00535-EXC-DC 04-14.pdf
7		Eligibility for Coverage	SBC–00535 –ELI/DC 04/14	MTX	Initial			SBC-00535-ELI-DC 04-14.pdf
8		Benefits	SBC–00535 –BEN 04/14	MTX	Initial			SBC-00535-BEN 04-14.pdf
9		PARTICIPATION AGREEMENT	SBC–00991 –GPA/DC 8/12	AEF	Initial			SBC-00991-GPA-DC 8-12.pdf
10		Evidence of Insurability	SBC-00531-EOI 3/14	AEF	Initial			SBC-00531-EOI 314.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage

SERFF Tracking #:	*FRCS-130232387*	***State Tracking #:***	***Company Tracking #:*** *6380*

State:	*District of Columbia*	***Filing Company:***	*Symetra Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Select Benefits Critical Illness Policy*		
Project Name/Number:	*Symetra/65/6380*		

OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

SYMETRA
RETIREMENT | BENEFITS | LIFE

[SELECT BENEFITS]

[POLICY NAME]

[Notice: The Policy is a fixed-payment insurance policy. It provides fixed-payment medical [and other] benefits. The Policy is not comprehensive medical coverage and is not intended to cover the cost of all hospital or other medical services. The Policy does not satisfy the minimum essential coverage requirements of the Affordable Care Act.]

Limited Benefit, Please read carefully

INTRODUCTION

This **Policy** is divided into three sections:

a. The Policy Specifications section.
b. The [**Eligible Group**] section.
c. The Certificate of Coverage section.

All sections together form the **Policy** and include all of the benefits available under a plan.

The [**Eligible Group**] will be responsible for giving the Certificate of Coverage section to the **Certificateholder**.

Whenever we use the terms “you or your” in the [**Eligible Group**] section, we mean the [**Eligible Group**].

Whenever we use the terms “you, your or yourself” in the Certificate of Coverage section, we mean the **Certificateholder**[and/or **Certificateholder’s Dependents**].

Definitions of terms that appear in bolded print are included in the Certificate of Coverage section.

[Notice: The Policy is a fixed-payment insurance policy. It provides fixed-payment medical [and other] benefits. The Policy is not comprehensive medical coverage and is not intended to cover the cost of all hospital or other medical services. The Policy does not satisfy the minimum essential coverage requirements of the Affordable Care Act.]

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
1-800-796-3872
TTY/TDD 1-800-833-6388

SYMETRA®
RETIREMENT | BENEFITS | LIFE

POLICY SPECIFICATIONS

Policyholder:	[Legal Name]
[Master Policy Number:	XXXXXXXXX]
[Master Policy Effective Date:	mm-dd-yy]
[[Eligible Group]:	Legal Name]
Policy Number:	[XXXXXXXXX]
Policy Effective Date:	[mm-dd-yy]
Premium Due Date:	**Premium** is due on the Policy Effective Date and the first of each month beginning with [mm- dd -yyyy]
Policy Anniversary:	[Month] [day] of each year beginning in [yyyy]
Governing Jurisdiction:	This **Policy** is delivered in and governed by the laws of the state of [State]

This **Policy** has been issued in consideration of the signed master application, [the application of the **Eligible Group**] and payment of **Premium**. The [**Eligible Group**]'s coverage under this **Policy** renews on each Policy Anniversary.

[Symetra Life Insurance Company issues this **Policy** and agrees to pay the benefits of this **Policy** subject to its terms and conditions.

Symetra Life Insurance Company has, by its President and Secretary, executed this **Policy** as of this [Master] Policy Effective Date and caused it to be duly countersigned at Bellevue, Washington.

Thomas Marra,
President

David Goldstein,
Secretary]

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
1-800-796-3872
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[SELECT BENEFITS]
[FIXED-PAYMENT INDEMNITY POLICY]

[**Eligible Group]** Name:	[Legal Name]
Policy Number:	[##########]
Effective Date of Coverage	[mm/dd/yyyy]

[**ELIGIBLE GROUP**] SECTION

POLICY CONTENTS

[

]

SCHEDULE OF PREMIUM RATES

[

Initial Rate:

Coverage	[Monthly] Rate

]

Rate Guarantee:

A change in the initial premium rate will not take effect prior to [12-36 months] following your **Effective Date of Coverage**. However, the premium rate may change prior to this time for reasons that affect the insured risk, which include:

a. A change occurs in the benefits provided under the Policy.
b. A division, subsidiary, or affiliated company (known as associated entity) is added or deleted.
c. The number of [**Employees**] insured under the **Policy** changes by [15%-40%] or more.
d. A new law or a change in any existing law is enacted which applies to the benefit coverage.

We will notify you in writing at least [31-120 days] before a premium rate change is effective. A change may take effect on an earlier date if you agree to it.

ASSOCIATED ENTITIES

[

Insurance is extended to the [**Eligible Group**]'s associated entities, if any, listed below. Additions and deletions may only be made by **Amendment** to this **Policy**. Deletion of an associated entity is treated as termination of coverage under this **Policy** for that entity.

[Name	[Effective Date	[Termination Date
XXXXXXXXX]	mm/dd/yyyy]	mm/dd/yyyy]

]

[ELIGIBLE GROUP] PROVISIONS

Assignment

The coverage provided under this **Policy** is not assignable, except as otherwise stated in this **Policy**.

Conformity With Law

Any provision of this **Policy** which is in conflict with applicable state statutes, or any federal statutes, is hereby amended to conform to the minimum requirements of such statutes.

Inadvertent Error

The **Insured** will not lose the amount of coverage due him because of inadvertent error by you:

a. To provide the name of the **Insured** to us.
b. To report a change in the amount of the **Insured's** coverage to us.

Failure to report the termination of coverage of any **Insured** to us will not continue the coverage beyond the date it would otherwise end.

You have no authority to pay **Premium** for individuals that are not [**Employees**] or to continue coverage of terminated [**Employees**]. Payment of **Premium** will not effect or continue an individual's coverage if it should not be in effect or continue in effect. **Premiums** and benefits will be adjusted based on the true facts.

Misstatement of Age

If the age of an **Insured** has been misstated, the benefit payable will be the benefit to which he is entitled due to actual age.

Policy Changes

The coverage under this **Policy** may be changed at any time by written agreement between Symetra and officers of the [**Eligible Group**]. Changes will be valid only if approved by an officer of Symetra and endorsed or attached to this **Policy**, and do not require the consent of any **Insured**. No agent has the authority to change this **Policy** or to waive any of its provisions.

Entire Contract

All **Policy** sections, the master application, [the application of the **Eligible Group**], all **Amendments** or **Riders** and, to the extent required by law, the applications, if any, of the insured persons form the entire contract.

Statements Not Warranties

In the absence of fraud, all statements made by you or by any **Insured** will be deemed representations and not warranties. These statements will not be used to reduce or deny benefits unless the statements are in a written application signed by you or the **Insured**.

Pronouns

Masculine pronouns used in this **Policy** will apply to both genders.

Records of the [Eligible Group]

You will give such data as may be required by us to provide the coverage. This includes data on persons who are eligible to become covered, changes in the amount of coverage, and terminations of coverage.

You may add eligible [**Employees**] [and/or **Dependents**] periodically in accordance with the terms of the **Policy**.

Your records that we believe have a bearing on coverage under the **Policy** are open for our review at any reasonable time.

Personnel and other records pertaining to coverage under this **Policy** will be open for review by us at any reasonable time. Any additional records of yours as may have a bearing on the coverage shall also be open for review by us at any reasonable time.

Incontestability of Policy

We will not contest this **Policy** after it has been in force for two years with respect to you, except for:

a. Nonpayment of **Premium**.
b. Fraudulent misstatements by you.

No statement made by an **Insured** relating to his insurability will be used to contest his coverage:

a. After his coverage has been in force during his lifetime for two years; and
b. Unless such statement is in writing and signed by him.

Workers' Compensation

This **Policy** is not in lieu of and does not affect any requirements for coverage by **Workers' Compensation** Insurance.

Payment of Premiums

The first **Premium** will be due on your **Effective Date of Coverage** under this **Policy**. After that, **Premium** will be due [monthly], unless you and Symetra agree on some other method of **Premium** payment.

Grace Period

If you have not given written notice to us before the **Premium** due date to terminate coverage under this **Policy**, a grace period of [31-90 days] will be given in which to pay the **Premium** then due. Coverage will continue in force during this grace period. If the **Premium** is not paid before the end of the grace period, coverage will cease on the last day of the grace period and you will be liable to us for any unpaid **Premium** for the time coverage was in force.

If, before the end of the grace period, you give written notice to us that coverage is to be terminated, coverage will terminate on the later of the date contained in the notice or the date such notice is received by us. A pro rata **Premium** will be due for the period between the date the **Premium** was due and the date coverage ends.

Reinstatement

If your coverage ceases, we may reinstate such coverage, if requested in writing by you, and:

a. All past due **Premiums**, including the grace period **Premium** are paid; and
b. The current **Premium** is paid.

Policy will be reinstated lacking such approval, upon the 45th day following the date of conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application.

Change in Premium Rates

We may change the premium rate for any coverage by giving you [31-120 days] written notice. We may change the rates on:

a. The first Policy Anniversary.
b. Any **Premium** due date after the first Policy Anniversary.
c. Any **Amendment** or **Rider** effective date.

Premium Adjustment

Premium adjustment will be made when necessary. Refunds and credits are limited to **Premiums** received during the [3-12-month] period prior to receipt of request for adjustment.

Termination by the [Eligible Group]

You may terminate your coverage provided under this **Policy** by mailing to us [31-90 days] prior written notice stating when such termination will be effective.

Termination by Symetra

We may terminate your coverage under this **Policy** by giving at least [45-120 days] prior written notice, when:

a. You fail to comply with the minimum participation and contribution rules.
b. Fraud upon us has occurred.
c. You do not duly perform in good faith your obligations under this **Policy**.

We may terminate your coverage under this **Policy** by giving at least [10-60 days] prior written notice, when you do not pay all **Premiums** that are due by the end of the grace period.

We may also terminate your coverage under this **Policy** at any time for any reason after it has been in force for [12-36 months], provided we give [45-120 days] prior written notice.

All written notices will be delivered to you, or mailed to your last known address as shown on our records and we will indicate in that notice the reason for the termination.

Renewal

We may renew your coverage under this **Policy** on each Policy Anniversary by giving you [20-90 days] prior written notice, indicating in that notice the amount of **Premium** due.

We may refuse to renew your coverage under this **Policy** by giving you [45-120 days] prior written notice indicating in that notice the reason for nonrenewal of your coverage under this **Policy**.

[ERISA

This **Policy** is delivered in and is governed by the laws of the state of [State] and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments to ERISA.]

Symetra Life Insurance Company
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[SELECT BENEFITS]
CRITICAL ILLNESS POLICY

Policyholder:
[Name Legal Name]
[Master Policy Number: ##########]
[Master Policy Effective Date: mm/dd/yyyy]

[Eligible Group:]
[Name: Legal Name]
[Policy Number: ##########]
[Effective Date of Coverage: mm/dd/yyyy]
[Policy Anniversary mm/dd]

CERTIFICATE OF COVERAGE

LIMITED BENEFIT, PLEASE READ CAREFULLY

INTRODUCTION

This is your Certificate of Coverage. It describes the benefits provided through your [**Eligible Group**] under the **Policy** issued by Symetra Life Insurance Company (referred to as "we, us or our").

This certificate summarizes the major provisions of the **Policy**, which are important to you. The complete terms of the coverage provided are set forth in the **Policy**.

The terms "you, your or yourself" referred to in this Certificate of Coverage mean the **Certificateholder**[and/or **Certificateholder's Dependents**].

Masculine pronouns used in this certificate will apply to both genders.

[YOU DO NOT HAVE COVERAGE FOR THE BENEFITS DESCRIBED IN THIS CERTIFICATE UNLESS THEY ARE LISTED IN THE **[SCHEDULE OF BENEFITS]**, OR AS AMENDED.]

Keep this certificate in a safe place. Instructions for submitting a claim for benefits appear at the end of this certificate.

This Certificate of Coverage replaces all others previously issued.

NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.

CERTIFICATE TABLE OF CONTENTS

[

CERTIFICATE TABLE OF CONTENTS (CONTINUED)

]

[SCHEDULE OF BENEFITS]

[

Eligible Class(es) for Coverage

[Eligible class(es) of [**Employees**] is defined as follows:

Class	Description
	All regular [full-time; part-time; hourly; salaried] [**Employees**], as defined by your [**Eligible Group**], who have worked and been paid for at least a minimum of [10-40] hours each [week; month] at your [**Eligible Group**'s] normal place of business.]

[Service Waiting Period

[If you are in an eligible class on your [**Eligible Group**]'s **Effective Date of Coverage**, there is no **Service Waiting Period**. Otherwise,] the **Service Waiting Period** is [1-6 months] of continuous employment [following the date you become a member of an eligible class].

]

[Annual Enrollment Period

Month Day through Month Day as determined by your [**Eligible Group**] on a yearly basis.]

]

[Benefit Waiting Period

The **Benefit Waiting Period** is [30 days] following the date your coverage [or an increase in coverage] under the **Policy** takes effect.]

]

[Employee] Critical Illness Benefit

- **Critical Illness Benefit** — [Choice of:] [$5,000 to $100,000] [in $1,000 increments] per [category of] critical illness

  The [**Employee's**] Critical Illness Benefit amount is reduced by [50%] on [the [coverage][**Policy**] anniversary date that occurs on or follows] the [**Employee's**] [65th] birthday

- **Guaranteed Issue Amount** — [$15,000 to $25,000]
- **Buy-up Amount** — [$5,000]
- **Recurrence Benefit** — [25%, 50%, 100%] of the Critical Illness Benefit paid for the first occurrence of the same condition

- **Health Screening Benefit** — [$50, $100, $150] per person, per **Calendar Year**

Spouse Critical Illness Benefit

- **Critical Illness Benefit** — [$2,500 to $50,000] [50% of the [**Employee's**] benefit] per [category of] critical illness

  The Spouse Critical Illness Benefit amount is reduced by [50%] on [the [coverage][**Policy**] anniversary date that occurs on or follows] the [**Employee's**] [Spouse's] [65th] birthday.

- **Guaranteed Issue Amount** — [$5,000]
- **Recurrence Benefit** — [25%, 50%, 100%] of the Critical Illness Benefit paid for the first occurrence of the same condition
- **Health Screening Benefit** — [$50, $100, $150] per person, per **Calendar Year**

Child Critical Illness Benefit

- **Critical Illness Benefit** — [$1,250 to $10,000] [25% of the [**Employee's**] benefit][, not to exceed $10,000] per [category of] Critical Illness

  The Child Critical Illness Benefit amount is reduced by [50%] on [the [coverage][**Policy**] anniversary date that occurs on or follows] the [**Employee's**] [65th] birthday.

- **Guaranteed Issue Amount** — [$10,000]
- **Recurrence Benefit** — [25%, 50%, 100%] of the Critical Illness Benefit paid for the first occurrence of the same condition

[From time to time we may offer or provide to you noninsurance benefits and services. In addition, we may arrange for third party service providers to give access to you to discounted goods and services. While we have arranged for this access, the third party service providers are liable to you for the provision of such goods and/or services. We are not responsible for the provision of such goods and/or services nor are we liable for the failure of the provision of the same. Further, we are not liable to you for the negligent provision of such goods and/or services by third party service providers.]

]

DEFINITIONS

[

Accident: a sudden, unforeseen, unexpected and involuntary event definite as to time and place and which is independent of disease or bodily infirmity.

Actively at Work: you are at work with your [**Eligible Group**] on a day that is one of your [**Eligible Group**'s] scheduled workdays. On that day, you must be performing, for wage or profit, all of the normal duties of your job:

a. In the usual way.
b. For your usual number of hours.
c. At your [**Eligible Group**'s] normal place of business, or alternate location, if approved by the [**Eligible Group**].

You are also considered to be Actively at Work on any regularly-scheduled vacation day or holiday, only if you were Actively at Work on the preceding scheduled work day.

Amendment: a document that modifies the **Policy** or Certificate, and becomes part of the **Policy** or Certificate, also known as a **Rider**.

Benefit Waiting Period: the exclusionary period immediately following your **Effective Date of Coverage** [or the date an increase in coverage takes effect]. No benefit [or benefit increase] is payable for a critical illness that is diagnosed during the Benefit Waiting Period.

Benefit Year: The time, designated by your [**Eligible Group**], during which the benefit elections you make during annual enrollment are in effect.

Buy-up Amount: the amount that you may be able to add to your benefit after [two years] of continuous coverage under the **Policy** without having to provide evidence of insurability.

Calendar Year: the period from January 1 through December 31 of the same year.

Certificateholder: the [**Employee**] who is eligible for coverage under the **Policy**, who is enrolled and for whom **Premium** is paid.

Dependent: the following persons:

a. [Your spouse, as defined by state law.] [Your spouse or [civil union partner or] same or opposite sex domestic partner as permitted or required to be recognized as a dependent under state or federal law.] [Your spouse, as defined by state law, or your same or opposite sex [civil union partner or] domestic partner]. [All references to spouse, or any other term that denotes a spousal relationship, used in this Certificate will apply to a [civil union partner or] domestic partner.]
b. Your child who is under [26-30] years of age (Limiting Age).
c. Your [unmarried] child, who is incapable of self-support due to a disabling physical or mental impairment, provided the disabling condition occurs prior to age [26-30].
d. Your niece, nephew, or grandchild who You provide regular and primary care during the time that District of Columbia public schools are in session who are unmarried and under the age of 19.

DEFINITIONS (CONTINUED)

A child includes: stepchildren; legally-adopted children; foster children, including any children legally placed with you for adoption; any children you support under court order; any other children, related to you by blood or marriage [or a civil/domestic partnership], who live with you in a regular parent-child relationship; or any children you claimed as a dependent on your last-filed federal income tax return.

Effective Date: the date on which coverage under the **Policy** begins.

Effective Date of Coverage: the date coverage under the **Policy** goes into effect for a [**Eligible Group**] and for any eligible [**Employees**][and **Dependents]**.

[Employee]: a person who is[:

a. Employed by, and paid by, the [**Eligible Group**].
b. Working under exclusive contract with, and paid by, the [Eligible Group],
c. An individual proprietor or partner of the [Eligible Group].]

Guaranteed Issue Amount: the amount of benefit available without having to provide evidence of insurability [on the date you [or your spouse] [or your **Dependent**] are first eligible for coverage under the **Policy**].

Injury: bodily harm that is caused by an **Accident** and results directly from the **Accident** and independently of all other cause.

Insured: a person who is eligible for coverage under the **Policy** as an [**Employee**][or as a **Dependent]**, is enrolled, and for whom **Premium** is paid.

[**Eligible Group**]**:** the entity, named in this Certificate, who has obtained coverage under the **Policy**.

Policy: the contract between us and the **Policyholder**. The Policy is comprised of the Policy Specifications, the [Eligible Group] section and this Certificate. This certificate describes all of your covered benefits under the Policy.

Policyholder: the entity identified on the master application for the **Policy** as such and to whom the **Policy** is issued.

Premium: the dollar amount paid by your [**Eligible Group**] and/or you to keep the **Policy** in force.

Prior Coverage: any critical illness, specified disease, or any other like coverage which your [**Eligible Group**] has replaced with coverage under the **Policy**.

The cost of the Prior Coverage must have been paid through its date of termination. The termination date must have occurred within [1 day] of your [**Eligible Group**]'s **Effective Date of Coverage** under the **Policy**.

Proof of Loss: a statement that must be furnished by you to us before any benefits may be paid under the **Policy**.

Provider: any doctor, health professional, hospital, nursing facility, home health agency or other person or recognized entity licensed to provide hospital or medical services to **Insureds** covered under the **Policy**.

DEFINITIONS (CONTINUED)

Rider: a document that modifies the **Policy** or Certificate, and becomes part of the **Policy** or Certificate, also known as an **Amendment**.

Service Waiting Period: the length of time you must wait from your date of employment [or if later, the date you become a member of an eligible class before your coverage can begin.]

[Schedule of Benefits]: are the pages of the Certificate, which list the benefits available to you as selected by your [**Eligible Group**].

Specialist: a person who:

a. Is licensed and recognized as a doctor by the state in which he practices.
b. Is practicing within the scope of his license.
c. Is board eligible or board certified in the appropriate specialty or sub-specialty needed to diagnose and treat the diseases or conditions covered as a critical illness under the **Policy**.

Examples of a Specialist are:

a. Cardiologist for Heart Attack
b. Neurologist for [Advanced Alzheimer's Disease] [Moderately Severe Alzheimer's Disease]
c. Ophthalmologist for Loss of Sight
d. Oncologist for Invasive Cancer

A Specialist is not a person who:

a. Ordinarily resides in your household.
b. Is a member of your immediate family.
c. Is employed by or affiliated with your [Eligible Group].

]

GENERAL PROVISIONS

Notice of Claim

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at:

Symetra Life Insurance Company
118 Third Street East
P.O. Box 440
Ashland, WI 54806
1-800-497-3699

or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

If you are not able to notify us within the applicable time period, then you must notify us as soon as reasonably possible. Your notice must include the claimant's name, address and the Policy Number.

Claim Forms

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.Proof of Loss

Proof of Loss may include, but is not limited to, the following[:

a. A completed claim form.
b. Documentation of:
    i. The date the Covered Critical Illness began.
    ii. The cause of the Covered Critical Illness.
    iii. Satisfaction of the diagnosis requirements for the Covered Critical Illness.
c. The names and addresses of all **Specialists** and other health care **Providers for the Covered Critical Illness**.
d. Your signed authorization for us to obtain and release medical information.
e. Any additional information required by us to make a determination on the claim.]

All proof submitted must be satisfactory to us.

Written **Proof of Loss** must be furnished within 90 daysThe date of diagnosis for a Covered Critical Illness.

f. The date a health screening test is provided]

If it was not possible to give us proof by the time it is due, then you must give us proof as soon as possible. Unless you, or the person who has the right to claim benefits, is not legally competent, **Proof of Loss** must be given no later than [one year] after it is due.

Time Payment of Claims

We will pay benefits immediately upon receipt of due written proof of such loss.

Payment of Benefits

Benefits payable under the **Policy** will be paid directly to:

a. You.
a. Your legally appointed guardian if you are not legally able to accept such benefits.
b. Your estate, in the event any payment is owed at the time of your death.

Any payment made in good faith fully discharges us to the extent of that payment.

Physical Examination and Autopsy

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by lawExamination of Specialist's Records

We may, at our expense, examine your **Specialist's** or other **Provider's** records as often as reasonably necessary while a claim pending.

Right to Appeal a Denied Claim

If you disagree with a decision on a claim, you or your representative may, within 180 days of receiving an initial denial notice appeal the decision by submitting a written request to:

[Symetra Life Insurance Company
118 Third Street East
P.O. Box 440
Ashland, WI 54806
1-800-497-3699]

Your written request should include:

a. A statement of the reasons(s) for disagreement;
b. Documentation of any new facts or data that apply to the claim.

If your written request for review is not received within 180 days of receiving a denial notice, you will forfeit your right to an appeal.

Legal Actions

No legal action may be brought to recover a disputed claim amount under the **Policy**:

a. Until [180 days] have elapsed after **Proof of Loss** has been filed; or
b. After [3 years] from the end of the time within which **Proof of Loss** is required by the **Policy**.

EXCLUSIONS AND LIMITATIONS

In addition to the Exclusions and Limitations listed in the Benefits section, this section applies to all benefits under the **Policy**.

Pre-existing Conditions Limitation

No benefit will be paid for any critical illness caused by or resulting from a pre-existing condition if it is diagnosed in the first [6 months] after the **Insured's** coverage takes effect.

A pre-existing condition means an illness or **Injury** for which the **Insured** received treatment during the [12 months] immediately before the **Insured's** coverage takes effect. The **Insured** is considered to have received treatment if the **Insured**:

a. Was provided medical care or services.
b. Was diagnosed.
c. Had medical diagnostic testing.
d. Received medical advice.
e. Took prescribed drugs or medications.

Benefit Increases
If [you increase the amount of your benefit during an Annual Enrollment Period][your benefit amount increases], the amount of the benefit increase will not be paid for any critical illness caused by or resulting from a pre-existing condition if it is diagnosed in the first [6 months] after your increase in coverage takes effect.

A pre-existing condition means an illness or **Injury** for which you received treatment during the [6 months] immediately before your increase in coverage takes effect. You are considered to have received treatment if:

a. You were provided medical care or services.
b. You were diagnosed.
c. You had medical diagnostic testing.
d. You received medical advice.
e. You took prescribed drugs or medications.

[A Pre-existing Condition Limitation does not apply to the **Buy-up Amount.**]

]

Exclusions

No benefit is payable for any illness, **Injury**, or disease that is not specifically named or described in the Benefits section. Further, no benefit will be paid when the **Insured** has a critical illness that is:[

a. Diagnosed before the **Insured** is covered under the **Policy**.
b. Diagnosed after the Insured's coverage terminates, except as provided under the **Policy**.
c. Diagnosed during any **Benefit Waiting Period**.
d. Not diagnosed by a **Specialist**.
e. Diagnosed by a physician outside the United States
f. Diagnosed more than once while covered under the **Policy**[, except as provided under the Recurrence Benefit].

EXCLUSIONS AND LIMITATIONS (CONTINUED)

g. Contributed to or caused by: another Covered Critical Illness, a complication of another critical illness, or treatment of another critical illness for which the **Insured** has been paid a benefit under the **Policy**.
h. Caused wholly or partly, directly or indirectly by:
    i. Declared or undeclared war or act of war
    ii. Committing or attempting to commit an assault or felony
    iii. Inciting or taking part in any form of public violence
    iv. Intentionally self-inflicted **Injury**, while sane or insane
    v. Full-time active duty as a member of the armed forces (land, water, air) of any country or international authority.
    vi. Being intoxicated or under the influence of alcohol, drugs or any narcotic (including overdose) unless as prescribed by or administered by a physician
    vii. Alcoholism or drug addiction.

ELIGIBILITY FOR COVERAGE

Eligible [Employees]

You are eligible for coverage under the **Policy** if you [meet all of the following conditions:

a. Are performing all the normal duties of your job at the normal place of business of the [**Eligible group**].
b. Are a member of an eligible class as described in the **[Schedule of Benefits]].**

The Date You Are Eligible for Coverage
You first become eligible for coverage on the later of:

a. The [**Eligible group**]'s **Effective Date of Coverage**.
b. [The [first of the month following the] date on which you complete the **Service Waiting Period**.]
c. The [first of the month following the] date you become a member of an eligible class.

Enrollment
In order to become covered for the benefits under the **Policy**, you must first enroll in writing [and submit any evidence of insurability] on a form approved by us giving the information we require. [You may only enroll at the following times:

a. Within [30-60 days] of your eligibility date.
b. During an Annual Enrollment Period designated by the [**Eligible group**].
c. Within [30-60 days] of the date you have a qualified life event change.]

This enrollment period will be waived when a parent is required to enroll a child due to a court or administrative order.

[Life Event Changes:
Life event changes that qualify you to enroll earlier than the next [Annual Enrollment Period] are:[

a. A change in your legal marital status, including marriage, divorce, legal separation, annulment, or death of a spouse [or a domestic [or civil] partner].
b. A change in the number of your **Dependents**, including birth, death, adoption, placement for adoption, award of legal guardianship.
c. A change in the eligibility of a **Dependent** due to reaching the limiting age or any similar circumstance.
d. A change in employment status which causes your spouse [or a domestic [or civil] partner] to become ineligible for group coverage.
e. A change in your classification from part-time to full-time or from full-time to part-time].]

[Evidence of Insurability
You [are] [may be] required to provide evidence of insurability, at your expense[, when:

a. You enroll for coverage [for the first time][more than [30-60 days] following the date you were first eligible].
b. You were eligible, but not enrolled, for coverage under **Prior Coverage** and enroll for coverage on the [**Eligible group**]'s **Effective Date of Coverage**.
c. You enroll for coverage in an amount greater than the **Guaranteed Issue Amount** shown in the [**Schedule of Benefits**].
d. You enroll for coverage following a qualified life event change.
a. You re-enroll for coverage, providing your previous coverage ended for the following reason:
    i. You requested the termination of coverage.
    ii. You failed to make the required contribution or **Premium** payment.]

ELIGIBILITY FOR COVERAGE (CONTINUED)

Evidence of insurability must be satisfactory to us. It may include, but will not be limited to:

a. A completed and signed application, including medical history.
b. A medical examination.
c. A statement from your doctor or other **Provider**.]

If your evidence of insurability is not satisfactory to us[:

a. Your Critical Illness Benefit amount will equal the **Guaranteed Issue Amount**, provided you enrolled within [30-60 days] of the date you first became eligible.
b. You will not be covered under the **Policy** [if the application was provided when you:
    i. Enrolled for coverage [for the first time] [more than [30-60 days] after the date you were first eligible to enroll].
    ii. Enrolled for coverage following a life event change.
    iii. Re-enrolled for coverage].]

Effective Date of Your Coverage
Your coverage becomes effective on [the first day of the month following] the latest of the following dates:

a. The date you become eligible (if you enroll before that date).
b. The date you enroll for coverage (if you do so within [30-60 days] from the date you first become eligible [or have a life event change]).
c. The date the next **Benefit Year** begins (if you enroll during an Annual Enrollment Period)
d. The date **Premium** is received
e. [The date we approve any required evidence of insurability.]

[If, because of illness or **Injury**, you are not **Actively at Work** on the date your coverage would normally take effect, your **Effective Date of Coverage** will be delayed until [the first day of the month following] the date you have returned to active work [for a period of 5 days]. [If you were absent from work for more than [30 days] following the date your coverage would normally take effect, you will be required to provide new evidence of insurability.]]

If you have any questions about your eligibility or enrollment, contact your [**Eligible group**].

[Eligible Dependents

This section applies if the **[Schedule of Benefits]** shows you are entitled to elect a Spouse or Child Critical Illness Benefit.

A family member is eligible for coverage under the **Policy** if all of the following conditions are met:

a. You are eligible for coverage under the **Policy**.
b. The family member qualifies as a **Dependent** as defined under the **Policy**.
c. The **Dependent** is not covered as an [**Employee**] under the **Policy**.

If both you and your spouse [(civil union partner[or domestic partner])] are covered under the **Policy** as [**Employees**], either, but not both, may elect to cover children who are eligible **Dependents**.

The Date a Dependent is Eligible for Coverage
A **Dependent** first becomes eligible to be an **Insured** on the later of:

a. The date you become eligible.

b. The [first day of the month following the] date you acquire a **Dependent** such as through marriage, birth, adoption, or placement for adoption.

Enrollment
In order for a **Dependent** to become an **Insured**, you must first enroll the **Dependent** in writing [and submit any evidence of insurability] on a form approved by us giving the information we require. You may enroll a **Dependent** at the same time as you enroll yourself for coverage. [If you have already enrolled yourself, you may add a **Dependent** at the following times:

a. Within [30 days] of the **Dependent's** eligibility date.
b. During an Annual Enrollment Period designated by the [**Eligible group**].
c. Within [30 days] of the date you have a qualified life event change.]

It is important that you promptly notify us of additional **Dependents** to assure accurate claim handling.

If you have not enrolled yourself, you may not enroll a **Dependent**.

[Evidence of Insurability
You [are][may be] required to provide evidence of the **Dependent's** insurability, at your expense, [when:

a. You enroll [the **Dependent**] [your spouse][for the first time] [more than [30 days] following the date [the **Dependent**] [your spouse] was first eligible].
b. You enroll [the **Dependent**] [your spouse] for coverage that exceeds the **Guaranteed Issue Amount** shown in the [**Schedule of Benefits**].
c. You re-enroll the [**Dependent**] [spouse] for coverage, providing the [**Dependent's**] [spouse's] coverage ended for one of the following reasons:
    i. You requested the termination of the [**Dependent's**] [spouse's] coverage.
    ii. You failed to make the required contribution or **Premium** payment.]

Evidence of insurability must be satisfactory to us. It may include, but will not be limited to:

a. A completed and signed application, including medical history.
b. A medical examination.
c. A statement from the [**Dependent's**] [spouse's] **Doctor** or other **Provider**].

If your [**Dependent's**] [spouse's] evidence of insurability is not satisfactory to us[:

a. Your [**Dependent's**] [spouse's] Critical Illness Benefit amount will equal the **Guaranteed Issue Amount**, provided you enrolled your [**Dependent**] [spouse] within [30 days] of the date your [**Dependent**] [spouse] first became eligible.
b. Your [**Dependent**] [spouse] will not be covered under the **Policy**[if the application was provided when you:
    i. Enrolled your [**Dependent**] [spouse] for coverage [for the first time] [more than [30 days] after the date your [**Dependent**] [spouse] was first eligible to enroll]
    ii. Enrolled your [**Dependent**] [spouse] for coverage following a life event change.
    iii. Re-enrolled your [**Dependent**] [spouse] for coverage].]

Effective Date of Dependent Coverage
Dependent coverage becomes effective on [the first day of the month following] the latest of the following dates:

a. The date the **Dependent** becomes eligible (if you enroll the **Dependent** before that date).
b. The date you enroll the **Dependent** for coverage (if you do so within [30 days] from the **Dependent's** eligibility date [or the date of a life event change]).
c. The date the next **Benefit Year** begins (if you enroll the **Dependent** during an Annual Enrollment Period)
d. The date **Premium** is received
e. [The date we approve any required evidence of insurability for yourself.]
f. [The date we approve any required evidence of insurability for your spouse.]

If you did not elect **Dependent** [child] coverage before the birth or adoption of a child, coverage will take effect for that child on the date of birth or adoption, if:

a. You notify us, in writing, of the birth or adoption of such child; and
b. Within 60 days of the date of birth or adoption, you [pay the required **Premium**] [or][authorize your [**Eligible group**] to deduct your required contribution toward the cost of your **Dependent** coverage from your pay].

If a **Dependent**, other than a newborn child, is confined to a hospital or other healthcare facility on the date he would otherwise become an **Insured**, he will become an **Insured** on the first day following his release from the hospital or health care facility. [If the **Dependent** was confined for more than [30 days] following the date he would otherwise become an **Insured**, you will be required to provide new evidence of the **Dependent's** insurability.]

If you have any questions about a **Dependent's** eligibility or enrollment, contact your [**Eligible group**].**]**

[Continuity with Prior Coverage

If you [and your **Dependents**] were insured under **Prior Coverage** on the day it terminated and enroll for coverage under the **Policy** to take effect on the [**Eligible Group**]'s **Effective Date of Coverage**[, the following provisions apply to prevent a loss of coverage.

Evidence of Insurability
If you enroll yourself [and your **Dependents**] for an amount of coverage that is equal to or smaller than the amount of coverage under **Prior Coverage**, evidence of insurability will not be required.

Evidence of insurability will be required if you apply for an increase in coverage.

Effective Date of Coverage
Your **Effective Date of Coverage** will not be delayed if you were not **Actively at Work,** because of an illness or **Injury**, on the date coverage under the **Policy** would otherwise take effect

[Coverage will not be delayed for a **Dependent** who is confined to a hospital or other healthcare facility on the date coverage under the **Policy** would otherwise take effect.]

Benefit Waiting Period
If the **Insured's** diagnosed condition was a covered critical illness under **Prior Coverage**, the amount of time the **Insured** was continuously covered under **Prior Coverage** will count toward satisfying the **Benefit Waiting Period.**

[The amount of time the **Insured** was continuously covered under **Prior Coverage** will not count toward satisfying the **Benefit Waiting Period** for increases in coverage.]

Pre-existing Conditions Limitation
If the **Insured's** diagnosed condition was a covered critical illness under any **Prior Coverage**, then the Pre-existing Conditions Limitation will be determined based on either:

a. The **Policy's** Pre-existing Condition Limitation as stated later in this certificate; or
b. The **Prior Coverage's** limitation taking into consideration the total amount of time the **Insured** was continuously covered under **Prior Coverage** and the **Policy**

If either the Pre-existing Conditions Limitation of the **Policy** or that of the **Prior Coverage** applies, no benefit will be paid.

If the limitation does not apply, a Critical Illness Benefit will be paid as shown within the benefit schedule and all other terms, conditions and limitations of:
a. the **Policy**; or
b. the **Prior Coverage**;

whichever is less.

In no event will:

a. A benefit be paid for a critical illness due to a pre-existing condition, if the critical illness is excluded by any other terms of the **Policy**.
b. A critical illness be considered to be due to a pre-existing condition under the **Policy** if it was not a pre-existing condition under any **Prior Coverage**.]

[The above Prior Coverage provisions do not apply to any increases in coverage or coverage that takes effect after the [**Eligible Group**]'s **Effective Date of Coverage**.]

]

Change in Amounts of Benefits

[The following paragraph applies if the **[Schedule of Benefits]** shows different benefit amounts based on class].

Any change in the amount of benefits due to a change in your class or status, is effective on [the first of the month following] the date your class or status changes, provided[:

a. You are performing all the normal duties of your job at your **[Eligible group's]** normal place of business.
b. You make any required contribution or **Premium** payment for the change to take effect.]]

Changes in the amount of benefits due to an **Amendment** or **Rider** to your [**Eligible group**]'s coverage under the **Policy**, take effect for an **Insured** on the effective date of the **Amendment** or **Rider**.

Benefits, payable under the **Policy**, are based on the coverage amounts in effect at the time a Covered Critical Illness condition is diagnosed. [A Pre-existing Conditions Limitation [and a] [new **Benefit Waiting Period**] applies to any increase in coverage.]

[Change in Amounts of Coverage

Once you have enrolled, you cannot make any changes in your elected coverage until your [**Eligible group**'s] next Annual Enrollment Period.

Increases in Coverage
You are eligible to increase coverage if all evidence of insurability previously submitted has been approved by us.

If you are eligible to increase coverage, [new evidence of insurability,][a Pre-existing Conditions Limitation] [and a] [new **Benefit Waiting Period**] [apply] [applies] to the increased amount[, except as provided under the Buy-up Benefit provision.]

If your evidence of insurability is not satisfactory to us, your Critical Illness Benefit amount will equal the amount that was in effect before you enrolled to increase coverage. You will not be able to increase coverage during any subsequent Annual Enrollment Period.

[If evidence of insurability for your [**Dependents**] [spouse] is not satisfactory to us, your [**Dependent's**][spouse's]] Critical Illness Benefit amount will equal the amount that was in effect before you enrolled to increase coverage.]

[Buy-up Benefit
You may enroll for the **Buy-up Amount** during the first Annual Enrollment Period following [two] full years of continuous coverage under the **Policy** if [.

a. A Critical Illness Benefit has not been paid under the **Policy**.
b. All evidence of insurability previously submitted has been approved by us.
c. The amount of your Critical Illness Benefit already in effect is less than the maximum amount available.]

[The amount of any Spouse [or Child]Critical Illness Benefit will also increase providing all evidence of insurability previously submitted for the Spouse [or Child] has been approved by us.]

[The amount of any Child Critical Illness Benefit will also increase.]

Evidence of insurability will not be required. [In addition, no Pre-existing Condition Limitation [or **Benefit Waiting Period**] will apply.]

This buy-up benefit will not apply and evidence of insurability will be required to increase coverage if a benefit was paid for a critical illness diagnosed during the [two-year] coverage period.

The buy-up benefit is available only once. Any increase in coverage requested during a subsequent Annual Enrollment Period will require evidence of insurability.]

Effective Date of Change
Any decrease in the amount of coverage is effective on the first day of the next **Benefit Year**.

Any increase in the amount of coverage is effective on the first day of the next **Benefit Year**, provided[:

a. You are performing all the normal duties of your job at your **[Eligible group's]** normal place of business; and
b. You make any required contribution or **Premium** payment for the change to take effect.
c. We approve any required evidence of insurability.]

Termination of Your Coverage

Your coverage will cease on the earlier of:

a. The date the **Policy** is canceled.
b. The date your [**Eligible group's]** coverage ceases under the **Policy**.
c. The [date] [last day of the month in which] the first of the following events occurs[:
    i. Your membership in an eligible class ceases.
    ii. Your employment with your [**Eligible group**] ceases.
    iii. You are no longer **Actively at Work**.
    iv. You or your [**Eligible group**] cease to make contributions or **Premium** payments for your coverage.
    v. You are pensioned or retired, as defined by your [**Eligible group**].
    vi. The date you begin full-time active duty as a member of the armed forces (land, water, air) of any country or international authority[,except as provided under the Continuation of Coverage provision].]

[Termination of Dependent Coverage

Dependent coverage, if applicable, will cease on the earliest of:

a. The date the **Policy** is canceled.
b. The date your coverage ceases.
c. The date all **Dependent** coverage ceases under the **Policy**.
d. The [date] [last day of the month in which] the first of the following occurs:
    i. You are no longer in a class eligible for **Dependent** coverage.
    ii. The family member ceases to be an eligible **Dependent**.

Coverage will be continued for a **Dependent** child beyond the limiting age for as long as the child is: [unmarried,] incapable of self-support because of a disabling mental or physical impairment and dependent on the **Certificateholder** for support.

Proof of the disabling impairment must be given to us no later than [31 days] after the date your child attains the limiting age. Subsequently, we have the right to require proof of your child's impairment, but not more often than once per year after two years from the date the limiting age is attained. **]**

[Continuation of Coverage During Temporary Absence

Coverage may continue beyond the day it would otherwise cease under the Termination provisions if you are absent from work due to any of the following reasons. Any continued coverage:

a. Is subject to payment of the required **Premium**.
b. Must be requested, in writing, by your [**Eligible Group**].
c. Terminates if:
    i. The **Policy** terminates.
    ii. Your [**Eligible Group**] ceases to be a [**Eligible Group**] under the **Policy**.
    iii. You begin work for pay or profit with another employer.

In no event will coverage continue beyond the maximum time shown below for any temporary absence. If you qualify to continue coverage for more than one reason, the periods of continuation will run concurrently. The continuation periods may not be applied consecutively.

Illness or Injury:
If you are absent from work due to illness or **Injury**, all of your coverage may be continued for a period of [3 consecutive months] from the date you were last **Actively at Work**.

ELIGIBILITY FOR COVERAGE (CONTINUED)

[Personal] Leave of Absence
If you are on an employer-approved leave of absence, all of your coverage may be continued for up to [1 month] following the date you were last **Actively at Work**. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Family Medical Leave of Absence
If you are on a leave of absence approved in accordance with the federal Family and Medical Leave Act of 1993 and any amendments to it (FMLA) or a similar state law, all of your coverage may be continued for up to [1 month] following the date you were last **Actively at Work**. If the leave terminates prior to the agreed upon date, this continuation will cease immediately. [Continuation under this FMLA leave provision will not apply if coverage may be continued for a longer period of time under the provision for temporary absence due to illness or **Injury**.]

Military Leave of Absence
If you are on a military leave of absence taken in accordance with the federal Uniformed Services Employment and Reemployment Rights Act of 1994 and any amendments to it (USERRA), all of your coverage may be continued for up to [1 week] following the date you were last **Actively at Work**. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Sabbatical
If you are on an employer-approved sabbatical, all of your coverage may be continued for up to [1 month] following the date you were last **Actively at Work**. If the sabbatical terminates prior to the agreed upon date, this continuation will cease immediately.

Temporary Layoff
If you are temporarily laid off by the [**Eligible Group**] due to lack of work, all of your coverage may be continued for up to [1 month] following the date you were last **Actively at Work**. If the layoff becomes permanent, this continuation will cease immediately.

Temporary Production Shutdown
If you are not at work due to a temporary production shutdown by the [**Eligible Group**], all of your coverage may be continued for up to [1 month] following the date you were last **Actively at Work**. If the production shutdown becomes permanent, this continuation will cease immediately.

Labor Strike/Labor Dispute
If you are not at work due to a labor strike or dispute, all of your coverage may be continued for up to [1 month] following the date you were last **Actively at Work**. If the labor strike or dispute ends earlier, this continuation will cease immediately.

[If any of the reasons for absence above apply to you, **Dependent** coverage may continue until your coverage ends.]

In all other respects, the terms of your [and your **Dependent**] coverage remain unchanged.

Upon written request from your [**Eligible Group**], we may agree to continue your coverage for reasons other than those temporary absences above, provided your [**Eligible Group**] provides a plan of continuation which applies to all [**Employees**] the same way.]

[Post-Termination Continuation of Coverage

[**Employee**] coverage may be continued following termination of employment if you meet all of the following conditions[:

a. You were **Actively at Work** on the date your employment ceases.
b. You had been continuously covered under the **Policy** for at least [6 months] prior to the date your coverage would have terminated.
c. You are under [65] years of age.
d. You are not pensioned or retired, as defined by your [**Eligible group**].
e. You are not scheduled for immediate deployment as a full-time member of the armed services of any country.]

[Post-termination continuation of coverage is not available for **Dependents**.]

You have 31 days from the date your employment ceases to elect continuation of coverage. If you choose to continue coverage you must pay the full cost of coverage each month. The coverage will be identical to the coverage you had immediately prior to the date your employment ceased.

Coverage may be continued up to the [date] [last day of the month in which] the first of the following events occurs[:
a. You have been covered under this Continuation of Coverage provision for [1 month].
b. You begin work for pay or profit with another employer.
c. You attain [65] years of age.
d. You are pensioned or retired, as defined by your [**Eligible group**].
e. You enter full-time active duty as a member of the armed forces (land, water, air) of any country or international authority.
f. You request, in writing, to cancel coverage.]

Any continued coverage:

a. Is subject to payment of the required **Premium**.
b. Terminates if:
    i. The **Policy** terminates.
    ii. Your [**Eligible Group**] ceases to be a [**Eligible Group**] under the **Policy**.
    iii. After you have been covered under this Continuation of Coverage provision for [31 days], we terminate your coverage.]

[Reinstatement

If you ceased to be eligible for coverage, coverage that terminated may be reinstated if you become eligible again within [90 days] from the date you were last eligible. Your reinstated coverage will be identical to the coverage you [and your **Dependents**] had immediately prior to termination. It will take effect on [the first day of the calendar month following] the date you become eligible again.

[Evidence of insurability will not be required to reinstate coverage.] [Any Pre-existing Condition Limitation [or **Benefit Waiting Period**] will apply to the same extent it would have applied before coverage terminated.]

If you do not qualify for reinstatement within [90 days] from the date you were last eligible, you will be treated as a new [**Employee**].]

Policy will be reinstated lacking such approval , upon the 45th day following the date of conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application

[Reemployment

If you are rehired, you will be treated as a new [**Employee**], unless your coverage may be reinstated as described in this Certificate.]

BENEFITS

Critical Illness Benefit

The Critical Illness Benefit will be paid if, while covered under the **Policy**, an **Insured** is diagnosed with a Covered Critical Illness as described below. The benefit payable is based on a percentage of the benefit amount in effect for the **Insured**. The benefit amount in effect is determined by [your choice of benefit amounts] [the benefit amount] as shown in the **[Schedule of Benefits]** and the result of our review of any evidence of insurability. [No benefit [or increase in benefit] is payable for conditions diagnosed during the **Benefit Waiting Period**.]

[Covered Critical Illness

[Category 1 Covered Critical Illness	Percentage of Benefit Amount Payable
Invasive Cancer	100%
Minor Cancer	25%]

[Category 2 Covered Critical Illness	Percentage of Benefit Amount Payable
Heart Attack	100%
Stroke	100%
Coronary Artery Disease Needing Surgery or Angioplasty	25%]

[Category 3 Covered Critical Illness	Percentage of Benefit Amount Payable
Coma Due to Accident	100%
Occupational HIV Infection	100%
Loss of Sight	100%
Loss of Speech	100%
Loss of Hearing	100%
Major Organ Failure	100%
End Stage Renal Failure	100%
Paralysis Due to Accident	100%
Severe Burns	100%]

[Category 4 Covered Critical Illness	Percentage of Benefit Amount Payable
Advanced Alzheimer's Disease	100%
Multiple Sclerosis	100%
Parkinson's Disease	100%
ALS and Other Motor Neuron Diseases	100%]

]

A benefit is payable once for a specific Covered Critical Illness. [A Recurrence Benefit may be payable if the same critical illness is subsequently diagnosed.]

Only one benefit is payable if the date of diagnosis of two or more critical illnesses is the same day. The single benefit paid will be for the Covered Critical Illness that provides the largest benefit amount. If the benefit amounts are equal, the benefit paid will be for the Covered Critical Illness selected by the [**Employee**].

A benefit may be payable for a different Covered Critical Illness if the dates when each of the conditions is diagnosed are separated by at least [18 months]**[**:

a. [18 months] for a critical illness in the same category.
b. [18 months] for a critical illness in another category.]

[Any benefit payable for a critical illness in the same category is limited to the difference between the following amounts:

a. 100% of the benefit amount in effect on the date when the new critical illness was diagnosed.
b. the amount of the benefit previously paid.**]**

Covered Critical Illness Descriptions

[Invasive Cancer
Invasive Cancer is defined as a malignant tumor characterized by the uncontrolled growth and spread of malignant cells with invasion and destruction of normal tissue. The term cancer includes leukemia, lymphoma, sarcoma, and Hodgkin's disease unless excluded below.

Diagnosis Requirements
Invasive Cancer must be diagnosed by a **Specialist** according to a Pathological or Clinical Diagnosis.

a. Pathological Diagnosis

   A diagnosis on a pathology report of Invasive Cancer based on a microscopic study of fixed tissue or preparations from the blood system. This type of diagnosis must be done by a **Specialist** whose diagnosis of malignancy conforms to the standards set by the American College of Pathology.

   If a pathological clinical diagnosis can only be made postmortem, liability shall be assumed retroactively beginning with the date of the terminal admission to the hospital for not less than 45 days before the date of death.

b. Clinical Diagnosis

   A diagnosis of Invasive Cancer based on the study of symptoms and diagnostic test results.

   We will accept a Clinical Diagnosis of Invasive Cancer only if the following conditions are met:

   i. A Pathological Diagnosis cannot be made because it is medically inappropriate or life threatening;
   ii. There is medical evidence to support the diagnosis; and
   iii. A **Specialist** is treating the Insured for Invasive Cancer.

Diagnosis Date
The date of diagnosis is the date of biopsy or other test that generates a definite diagnosis of cancer that satisfies the Invasive Cancer description.

Exclusions and Limitations
An Invasive Cancer Critical Illness Benefit will not be paid for the following cancers:

a. All tumors which are histologically described as benign, non-malignant, pre-malignant, borderline, low malignant potential, or dysplasia (all grades) or intraepithelial neoplasia;
b. Any lesion described as carcinoma in-situ (cancer which has not spread to neighboring tissue) that is classified as (Tis) by the AJCC Staging System;
c. Any lesion classified as Ta by the AJCC Staging System.
d. All non-melanoma skin cancers unless there are distant metastases;
e. Prostate cancer that is classified as T1 by the AJCC Staging System and has a Gleason Score that is less than or equal to 6, without lymph node or distant metastasis.
f. Any skin melanoma that is less than or equal to 1.0 mm in maximum Breslow thickness, without lymph node or distant metastasis;
g. Thyroid cancer that is classified as T1 by the AJCC Staging System and is less than or equal to 2 cm in diameter, without lymph node or distant metastasis.]

[Minor Cancer
Minor Cancer is defined as a diagnosis of one of the following four (4) malignant cancers:

1. Carcinoma in-situ (cancer which has not spread to neighboring tissue) that is classified as (Tis) by the AJCC Staging System, of all organs except skin.
2. Malignant prostate cancer that is classified as T1 by the AJCC Staging System and has a Gleason Score that is less than or equal to 6, without lymph node or distant metastasis.
3. Malignant melanoma of that is less than or equal to 1.0 mm in maximum Breslow thickness, without lymph node or distant metastasis;
4. Malignant thyroid cancer that is classified as T1 by the AJCC Staging System and is less than or equal to 2 cm in diameter, without lymph node or distant metastasis.

Diagnosis Requirements
The diagnosis must be confirmed with a report from a **Specialist** that includes the pathology report.

Diagnosis Date
The date of diagnosis is the date of biopsy or other test that generates a definite diagnosis of cancer that satisfies the Minor Cancer description.

Exclusions and Limitations
A Minor Cancer Critical Illness Benefit will not be paid for the following:

a. All tumors which are histologically described as benign, non-malignant, pre-malignant, borderline, low malignant potential, dysplasia (all grades) or intraepithelial neoplasia;
b. Non-melanoma skin cancer;
c. Carcinoma in-situ of the skin;
d. Melanoma in-situ.]

[Heart Attack (Myocardial Infarction)
Heart Attack (Myocardial Infarction) is defined as the ischemic death of a portion of the heart muscle due to a blockage of one or more coronary arteries. Heart Attack is a Covered Critical Illness when it is due to: [coronary artery disease, hypertension, dissection or similar disease].

Diagnosis Requirements
The diagnosis must be made by a **Specialist** and based on all three of the following criteria:

1. New clinical presentation.
2. Electrocardiographic changes consistent with an evolving Heart Attack (Myocardial Infarction).

3. Serial measurement of cardiac biomarkers in the blood showing a pattern and to a level consistent with a diagnosis of Heart Attack (Myocardial Infarction).

Diagnosis Date
The date of diagnosis is the date of the Heart Attack as confirmed by a **Specialist**.

Exclusions and Limitations
A Heart Attack Critical Illness Benefit will not be paid for the following:

a. Established or old heart attack (myocardial infarction) found on imaging or electrocardiogram.
b. Angina.
c. Cardiomyopathy.
d. Myocarditis.
e. All other forms of acute coronary syndromes.]

[Stroke
Stroke is defined as a cerebrovascular incident resulting in irreversible death of brain tissue due to intra-cranial hemorrhage or cerebral infarction due to embolism or thrombosis in an intra-cranial vessel. Stroke is a Covered Critical Illness when it is due to: [athlerothrombosis, cardioembolic disease or hypertension or similar disease].

Diagnosis Requirements
This event must result in permanent neurological functional impairment with objective neurological abnormal signs on physical examination by a **Specialist** at least 30 days after the event. The diagnosis must also be supported by findings on brain imaging and must be consistent with the diagnosis of a new Stroke.

Diagnosis Date
The date of diagnosis is the date of Stroke as confirmed by neurological evidence.

Exclusions and Limitations
A Stroke Critical Illness Benefit will not be paid for the following:

a. Transient Ischaemic Attacks (TIA);
b. Brain damage due to an accident, injury or hypoxia;
c. Vascular disease affecting the eye, optic nerve, or vestibular functions;
d. Asymptomatic silent stroke found on imaging.]

[Coronary Artery Disease Needing Surgery or Angioplasty
Coronary Artery Disease Needing Surgery or Angioplasty is defined as coronary artery disease with blockages in one or more coronary artery(s) demonstrated on cardiac catheterization coronary angiography that requires the **Insured** to undergo either coronary artery bypass surgery or coronary angioplasty.

Diagnosis Requirements
A **Specialist** must report that the Insured requires surgical intervention on the coronary artery(s) following clinically accepted cardiovascular surgery guidelines, either for prognostic benefit or for symptomatic coronary artery disease that cannot be adequately managed on optimal medical therapy.

Diagnosis Date
The date of diagnosis is the date the **Insured** is diagnosed with coronary artery disease that satisfies this Coronary Artery Disease Needing Surgery or Angioplasty description.

Exclusions and Limitations
A Critical Illness Benefit will not be paid for coronary artery conditions treated with non-surgical intervention procedures including, but not limited to, diagnostic coronary angiography.]

Coma Due to Accident
Coma Due to Accident is defined as a coma that results from an accidental **Injury** that occurred while covered under the **Policy**.

Diagnosis Requirements
This diagnosis must be supported by evidence of all the following:

a. No response to external stimuli for at least 96 hours.
b. Life support measures are necessary to sustain life.
c. Brain damage resulting in permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

Diagnosis Date
The date of diagnosis is the date the **Insured** entered a coma that persisted continuously for at least 96 hours.

Exclusions and Limitations
A Critical Illness Benefit will not be paid for the following:

a. Coma resulting from non-accident related causes including, but not limited to, stroke and alcohol or drug abuse.
b. Medically induced coma.

Occupational Human Immunodeficiency Virus (HIV) Infection Due to Accident
Occupational Human Immunodeficiency Virus (HIV) Infection is defined as infection with the human immunodeficiency virus (HIV) resulting from an accidental **Injury** which exposed the **Insured** to HIV-contaminated blood or bodily fluids during the course of the duties of the **Insured's** normal occupation.

The **Accident** causing the infection of HIV must have occurred in the United States and while covered under the **Policy.** In addition, the **Insured** must report the **Accident** to the employer within 24 hours of the **Accident**.

Diagnosis Requirements
All of the following conditions must be satisfied:

a. A blood test showing no HIV or HIV antibodies must be carried out within 14 days of the **Accident**;
b. Seroconversion must be proven with another HIV test within 180 days of the **Accident**, indicating presence of infection by HIV or AIDS

Diagnosis Date
The date of diagnosis is the date of the accidental **Injury** that caused the HIV infection.

Exclusions and Limitations
A Critical Illness Benefit will not be paid for the following:

a. HIV infection acquired via sexual transmission.
b. HIV infection acquired via intravenous (IV) drug use.

c. HIV infection determined not to be the result of an **Accident**.

[Loss of Sight
Loss of Sight is defined as permanent and irreversible loss of sight in both eyes. Loss of Sight is a Covered Critical Illness when it is due to an **Accident** or: [cataracts, glaucoma, or macular degeneration or similar disease].

Diagnosis Requirements
A **Specialist** must clinically confirm that the **Insured's** corrected visual acuity is 20/200 or less or the field of vision is less than 20 degrees in both eyes.

Diagnosis Date
The date of diagnosis is the date the diagnosis of blindness is confirmed by a **Specialist**.

Exclusions and Limitations
A Critical Illness Benefit will not be paid if the blindness is correctable by aides or surgical procedures.]

[Loss of Speech
Loss of Speech is defined as permanent loss of the ability to speak to the extent that the **Insured** is unintelligible to another person with normal hearing. Loss of Speech is a Covered Critical Illness when it is due to an **Accident** or: [Guillain Barre syndrome or Huntington's disease chorea or similar disease].

Diagnosis Requirements
The **Insured** must be able to demonstrate that the loss has been continuous for at least 180 days. The diagnosis of loss must be made by a **Specialist**.

Diagnosis Date
The date of diagnosis is the date the diagnosis of speech loss is confirmed by a **Specialist**.

Exclusions and Limitations
A Critical Illness Benefit will not be paid for loss of speech resulting from the following:

a. Stroke or Invasive Cancer.
b. All psychiatric causes.]

[Loss of Hearing
Loss of Hearing is defined as permanent reduction of hearing in both ears to a point that the Insured is unable to hear sounds at or below 90 decibels. Loss of Hearing is a Covered Critical Illness when it is due to an **Accident** or: [bacterial meningitis or Meniere's disease or similar disease].

Diagnosis Requirements
The diagnosis must be made by a **Specialist** as diagnosed by audiometric testing.

Diagnosis Date
The date of diagnosis is the date the diagnosis of hearing loss is confirmed by a **Specialist** meeting the **Policy** description of Loss of Hearing.

Exclusions and Limitations
A Critical Illness Benefit will not be paid for hearing loss that is correctable with aids or surgery.]

[Major Organ Failure
Major Organ Failure is defined as the failure of bone marrow, heart, liver, lung, pancreas, or small bowel. The organ failure is a Covered Critical Illness when it is due to: [Hypertensive Nephropathy, Cardiomyopathy or Cirrhosis or similar disease].

Diagnosis Requirements
A **Specialist** must determine that a transplant of one or a combination of the above mentioned organs is necessary to treat organ failure in the **Insured**. The **Insured** must be included on an official USA transplant waiting list such as the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP).

Diagnosis Date
The date of diagnosis is the date the **Insured** is placed on an official transplant list or listed with the National Marrow Donor Program.

Exclusions and Limitations
If an Insured is on the UNOS list for a combined transplant (example: heart and lung), a single benefit will be paid.

A Critical Illness Benefit will not be paid when an **Insured**:

a. Needs a transplant of any other organs, parts of organs, tissues or cells.
b. Is registered on an official transplant list as a donor.]

[End Stage Renal Disease
End Stage Renal Failure (Kidney Failure) is defined as the total and irreversible failure of both kidneys which requires permanent regular renal dialysis or a kidney transplant.

Diagnosis Requirements
A **Specialist** must confirm that either of the following is necessary:

a. The ***Insured*** must undergo regular renal dialysis at least weekly.
b. The **Insured** needs a kidney transplant and is included on an official USA transplant waiting list such as the United Network for Organ Sharing (UNOS)

Diagnosis Date
The date of diagnosis is the date a **Specialist** determines that permanent regular renal dialysis is necessary or the date the **Insured** is placed on an official transplant list.

Exclusions and Limitations
A Critical Illness Benefit will not be paid for acute reversible kidney failure that only needs temporary renal dialysis.]

[Paralysis Due to Accident
Paralysis Due to Accident is defined as paralysis with quadriplegia, paraplegia, hemiplegia, or diplegia, as the result of an **Accident** that occurred while covered under the **Policy.**

Diagnosis Requirements
There must be complete and permanent loss of use of two or more limbs that is present for a continuous period of at least 180 days.

Diagnosis Date
The date of diagnosis is the date of the **Accident** that has caused the paralysis as confirmed by a **Specialist.**

Exclusions and Limitations
A Critical Illness Benefit will not be paid for paralysis resulting from causes not related to an **Accident**, including but not limited to, stroke, cancer, coma, multiple sclerosis, Parkinson's disease, ALS and other motor neuron diseases.]

[Severe Burns
Severe Burns is defined as having sustained third degree burns.

Diagnosis Requirements
The third degree burns must cover at least 20% of the surface area of an **Insured's** body.

Diagnosis Date
The date a **Specialist** diagnoses the **Insured** with severe burns satisfying the Severe Burns description.

Exclusions and Limitations
A Critical Illness Benefit will not be paid when the degree of burn damage is classified as first-degree or second-degree.]

[Advanced Alzheimer's Disease
Advanced Alzheimer's Disease is defined as dementia due to Alzheimer's Disease, where there is progressive and permanent deterioration of memory and intellectual capacity.

Diagnosis Requirements
The diagnosis of Alzheimer's disease must be confirmed by a **Specialist** and the diagnosis must be supported by clinically accepted standardized cognitive testing and neurological examination.

There must be Advanced Alzheimer's Disease where there is significant reduction in mental and social functioning where the Insured is unable to perform independently, at least 2 of the following 5 "Activities of Daily Living" for a continuous period of at least 180 days:

Activities of Daily Living are defined as:

1. Washing - the ability to wash in the bathtub or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means (e.g., by sponge bath);
2. Dressing - the ability to put on, take off, secure and unfasten all items of clothing and, as appropriate, any braces, artificial limbs or other surgical appliances;
3. Transferring - the ability to move in and out of a bed, chair or wheelchair with or without the assistance of equipment;
4. Toileting - the ability to use the toilet or otherwise manage bowel and bladder functions so as to maintain a satisfactory level of personal hygiene;
5. Feeding - the ability to feed oneself once food has been prepared and made available.

Diagnosis Date
The initial diagnosis of Alzheimer's disease must occur while the **Insured** is covered under this **Policy**.

The date of diagnosis is the date a **Specialist** diagnoses the Insured with Alzheimer's disease satisfying the definition above.

Exclusions and Limitations
A Critical Illness Benefit will not be paid for other causes of dementia including, but not limited to, the following:

a. Psychiatric illnesses
b. Alcohol related brain damage
c. Stroke and vascular dementia
d. Parkinson's disease
e. Coma]

[Multiple Sclerosis
Multiple Sclerosis is defined as a diagnosis made by a **Specialist** of definite Multiple Sclerosis.

Diagnosis Requirements
Both of the following two (2) criteria must be present:

1. There must be permanent functional neurological impairment with objective evidence of motor or sensory dysfunction, which must have persisted for a continuous period of at least 180 days.
2. The diagnosis must also be confirmed with objective neurological investigations, such as lumbar puncture, evoked visual responses, evoked auditory responses and MRI evidence of lesions of the central nervous system.

Diagnosis Date
The date of diagnosis is the date the diagnosis of Multiple Sclerosis is confirmed by a **Specialist**.]

[Parkinson's Disease
Parkinson's Disease is defined as an unequivocal diagnosis of idiopathic Parkinson's disease.

Diagnosis Requirements
There must be resting tremor, rigidity, bradykinesia and gait disturbance compatible with the diagnosis of Parkinson's Disease as assessed by a **Specialist**.

Diagnosis Date
The date a **Specialist** diagnoses the **Insured** has having satisfied the Parkinson's Disease description.

Exclusions and Limitations
A Critical Illness Benefit will not be paid for drug-induced or toxic causes of Parkinsonism.]

[Amyotrophic Lateral Sclerosis (ALS) and other Motor Neuron Diseases
Amyotrophic Lateral Sclerosis (ALS) and other Motor Neuron Diseases is defined as a definite diagnosis by a **Specialist** of spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) or primary lateral sclerosis.

Diagnosis Requirements
There must be progressive degeneration of corticospinal tracts and anterior horn cells or bulbar efferent neurons. There must be permanent functional neurological impairment with objective evidence of motor dysfunction with muscle weakness that has persisted for a continuous period of at least 90 days.

Diagnosis Date
The date of diagnosis is the date the diagnosis of a covered motor neuron disease is confirmed by a **Specialist**.]

[Recurrence Benefit

This benefit applies only if it is shown in the [**Schedule of Benefits**].

The Recurrence Benefit will be paid, as shown in the [**Schedule of Benefits**], if a benefit has been paid under the **Policy** and the **Insured** is diagnosed again for the same Covered Critical Illness. All of the following conditions must be satisfied:

a. The subsequent condition is one of the Covered Critical Illnesses that qualifies for a recurrence benefit.
b. The subsequent condition satisfies the requirements as stated in the Covered Critical Illness Description and any additional conditions stated below.
c. The subsequent condition occurred and is diagnosed at least 365 days after the date of diagnosis for the paid Critical Illness Benefit
d. The subsequent diagnosis must be made while the **Insured** is covered under the **Policy**.

The Recurrence Benefit is payable only one time for each **Insured**.

Covered Critical Illness for Recurrence Benefit
The following conditions are Covered Critical Illnesses that may qualify for a recurrence benefit:

Invasive Cancer	Major Organ Failure
Heart Attack	Paralysis Due to Accident
Stroke	Severe Burns
Coma Due to Accident	

Conditions
To qualify for a recurrence benefit the following additional conditions must be satisfied:

Invasive Cancer
If an **Insured** was paid a Critical Illness Benefit for Invasive Cancer, a Recurrence Benefit may be paid if a **Specialist** reports that the Insured was cancer-free and had no evidence of cancer at least 365 days since the date of diagnosis of the first cancer.

This cancer-free state must be supported with clinical, radiological, histological and laboratory evidence to confirm there was no evidence of cancer for at least 365 days after diagnosis of the first Invasive Cancer.

This recurrence benefit will pay out if the second cancer is either a recurrence of the same cancer or a new cancer that meets the description of Invasive Cancer as stated in the **Policy**.

Major Organ Failure
If an **Insured** was paid a Critical Illness Benefit for Major Organ Failure, then the Recurrence Benefit will only pay out for a second Major Organ Failure if a **Specialist** reports that the originally-claimed Major Organ Failure was no longer present at least 365 days from the date of diagnosis of the first Major Organ Failure.

This Recurrence Benefit for Major Organ Failure will pay out if the **Insured** had a transplant that was functioning well at least 365 days after the transplant, but the transplanted organ subsequently fails again meeting the diagnosis requirements of Major Organ Failure as stated in the **Policy**.

This Recurrence Benefit will not cover failure of a second different major organ if a **Specialist** says that the first organ failure was still present 365 days after diagnosis of the first Major Organ Failure.

Heart Attack, Stroke, Coma Due to Accident, Paralysis Due to Accident, Severe Burns
If an **Insured** was paid a Critical Illness Benefit for any of the other critical illnesses listed under this Recurrence Benefit, then the second diagnosis must be a new acute event with a new diagnosis of the same critical illness and again meets the diagnosis requirements of the same critical illness.

Exclusions and Limitations
A Recurrence Benefit will not be paid when:

a. An **Insured** has already received payment for one Recurrence Benefit.
b. A subsequent diagnosis is made for Minor Cancer, Coronary Artery Disease Needing Surgery or Angioplasty, or any other critical illness that does not qualify for a recurrence benefit.

Health Screening Benefit

This benefit applies to you [and your spouse] only if it is shown in the [**Schedule of Benefits**]. [The Health Screening Benefit does not apply to a dependent child.]

The Health Screening Benefit will be paid when one or more of the following X-ray and laboratory tests are administered during a **Calendar Year**.

Tests to screen for Cancer
a. Biopsy
b. Bone marrow testing
c. Breast ultrasound
d. CA 125 (blood test for ovarian cancer)
e. CA 15-3 (blood test for breast cancer)
f. CEA (blood test for colon cancer)
g. Colonoscopy
h. Flexible sigmoidoscopy
i. Hemocult stool specimen
j. Mammogram
k. Pap test
l. PSA (prostate-specific antigen tests)
m. Serum protein electrophoresis (blood test for myeloma)
n. Thermography

Tests to screen for Heart-related Disease
a. Blood test for triglycerides
b. Chest x-ray
c. Serum cholesterol test to determine HDL/LDL level
d. Stress test on a bicycle or treadmill

Tests to screen for Organ-related Disease
a. Fasting blood glucose test

A Health Screening Benefit is payable once during a **Calendar Year**, regardless of the number of X-ray and laboratory tests administered during that year.

[Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, Washington 98004-5135

Mailing Address:
Select Benefit Administrators (SBA)
PO Box 440
118 3rd Street East (for overnight deliveries)
Ashland, WI 54806]

PARTICIPATION AGREEMENT

Participating Group: _____

Address: _____
(Street)

_____
(City) (State) (Zip)

The Participating Group hereby applies to participate in the Group Insurance Trust established by Symetra Life Insurance Company ("Symetra"), to provide its eligible members with the following group coverage under the insurance policy(ies) issued to [NAME] as Trustee of the Trust and governed under the jurisdiction of [STATE]:

Coverage	Requested Effective Date	Coverage	Requested Effective Date
[☐ Fixed Payment Indemnity	/ /]	[☐ Outpatient Prescription Drug	/ /]
[☐ Accident	/ /]	[☐ Critical Illness	/ /]
[☐ Name	/ /]	[☐ Name	/ /]

If Symetra approves participation, the coverage indicated above will be effectuated for the Participating Group pursuant to the selected Plan Summary. The Participating Group agrees its payment of premium after delivery of the policy(ies) shall constitute its acceptance and approval of all policy terms.

[☐ This Participation Agreement supersedes any previous agreement.]

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Signed at: _____ on: _____
(City) (State) (Date)

Participating Group:

_____
Authorized Representative Signature

_____
Name (printed) Title

Agent/Producer:

_____
Signature Resident Licensed Agent/Producer where required by law

_____
Name (printed) Tax ID Number

Instructions:
(1) Complete and sign the agreement
(2) Attach the Plan Summary and send to [Select Benefit Administrators (SBA)]
(3) Retain copy with your policy(ies)

[Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, Washington 98004-5135

Mailing Address:
Select Benefit Administrators (SBA)
PO Box 440
118 3rd Street East (for overnight deliveries)
Ashland, WI 54806]

Symetra Life Insurance Company
[777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135]

Mailing Address: Select Benefit Administrators
[PO Box 440 | Ashland, WI 54806
Overnight deliveries to: 118 3rd Street East | Ashland, WI 54806
Phone 1-800-497-3699 | Fax (715) 682-5919]

[CRITICAL ILLNESS] – EVIDENCE OF INSURABILITY FOR GROUP COVERAGE

Group Information *(To be completed by Policyholder)*

Group name	Requested effective date	Group number

Your Information *(To be completed by individual requesting coverage)*

Name (First, M.I., Last)	Gender	Date of birth
	☐ M ☐ F	
Spouse name (First, M.I., Last) ***(If coverage is requested)***	Gender	Date of birth
	☐ M ☐ F	

[Critical Illness] Benefit/Coverage Request

Evidence of Insurability Provided For:	Benefit amount requested
☐ Self ☐ Spouse	$_____

The following questions must be answered fully and truthfully, to the best of your knowledge and belief. If any misstatements or omissions are made, they may be the basis for later rescission of your insurance coverage. Rescission voids your coverage and claims will not be paid.

Health Information *(Complete for only those individuals applying for coverage)*

		Self	Spouse
1	Height	__ ft. ___in.	__ ft. ___in.
2	Weight	_____lbs	_____lbs.
3	In the last 12 months, have you smoked a cigarette or cigar, chewed tobacco or used tobacco or nicotine in any form including but not limited to electronic cigarettes, nicotine patch or nicotine gum?	**Yes** ☐ **No** ☐	**Yes** ☐ **No** ☐

4 Have you ever been diagnosed or treated for any of the following:

- Heart attack
- Heart failure
- Angioplasty
- Angina
- Coronary artery bypass
- Stroke
- Transient ischemic attack
- Cancer, leukemia, lymphoma (other than non-melanoma skin cancer)
- End-stage kidney disease on dialysis
- Liver cirrhosis
- Organ or bone marrow transplant
- Lung disease on home oxygen therapy
- Loss of speech (other than laryngitis)
- Multiple sclerosis
- Parkinson disease
- Dementia or Alzheimer's disease
- Motor neuron disease /amyotrophic lateral sclerosis (ALS) or Lou Gehrig's disease
- Human immunodeficiency virus infection, HIV or AIDS

	Self		Spouse	
	Yes	**No**	**Yes**	**No**
4	☐	☐	☐	☐

5 In the past 5 years, have you had any signs or symptoms of, been diagnosed with or been treated for any of the following:

		Self		Spouse	
		Yes	**No**	**Yes**	**No**
a.	Cardiomyopathy, heart valve disease, peripheral vascular disease or atrial fibrillation?	☐	☐	☐	☐
b.	Glomerulonephritis, protein or blood in the urine, or abnormal kidney function tests?	☐	☐	☐	☐
c.	Any lung disease requiring hospitalization for more than 24 hours?	☐	☐	☐	☐
d.	Chronic hepatitis B or C (or a carrier of) or inflammatory bowel disease (Crohn's Disease or Ulcerative Colitis)?	☐	☐	☐	☐
e.	Paralysis, muscle disease, other degenerative brain disease or any progressive loss of vision, hearing, speech, ear or eye disease (excludes refractive errors requiring corrective lenses)?	☐	☐	☐	☐
f.	Blood diseases (other than iron deficiency anemia, sickle cell trait or thalassemia minor), pre-malignant conditions, cancer in-situ?	☐	☐	☐	☐

		Self		Spouse	
		Yes	No	Yes	No
6	Have two or more of your natural parents and/or siblings been diagnosed with or died from any of the following conditions before the age of 60: cancer, heart disease, stroke, kidney disease, motor neuron disease, Parkinson's disease, dementia or Alzheimer's disease?	☐	☐	☐	☐
7	In the past 12 months, have you been informed by an attending physician of any abnormal test results or been advised to have any diagnostic test which has not yet been completed?	☐	☐	☐	☐
8	Are you currently waiting for results of any test (other than routine tests)?	☐	☐	☐	☐
	Are you currently waiting for referral to a specialist?	☐	☐	☐	☐
	Are you currently scheduled for surgery?	☐	☐	☐	☐

For any item marked with a "Yes" on questions 4-8, please indicate the condition and complete the details below. If additional space is needed, please attach a separate page.

Question #	Self/Spouse	Details of "Yes"answers	Onset Mo/Yr	Duration	Degree of Recovery	Full Name / Address of Attending Physician

Signature

By signing below, I agree that all information submitted on this form is to the best of my knowledge and belief is true and complete. I also agree that I have read and understand the fraud warning on the following page which applies to me.

Applicant's signature	Date
Spouse signature ***(If coverage is requested)***	Date

Please read the following notice that we are required by law to give to you.

For all states not named below: Any person who, with intent to defraud or knowing he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

AL: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

AR, LA, RI, WV: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

AZ: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CA: For your protection California law requires the following to appear hereon: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DE: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

ME: **It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.**

MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NH: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NJ: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NM: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

NY: The following applies to health insurance only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TN, VA, WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TX: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

SERFF Tracking #:	*FRCS-130232387*	***State Tracking #:***		***Company Tracking #:***	*6380*

State:	*District of Columbia*	***Filing Company:***	*Symetra Life Insurance Company*
TOI/Sub-TOI:	*H07I Individual Health - Specified Disease - Limited Benefit/H07I.001 Critical Illness*		
Product Name:	*Select Benefits Critical Illness Policy*		
Project Name/Number:	*Symetra/65/6380*		

Supporting Document Schedules

Satisfied - Item:	Authorization
Comments:	
Attachment(s):	DC_filing_authorization.pdf
Item Status:	
Status Date:	

Satisfied - Item:	SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION
Comments:	
Attachment(s):	LA_2184_1014.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Readability Certification
Comments:	
Attachment(s):	DC RDB Cert updated.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Statement of Variability
Comments:	
Attachment(s):	SBC-00535 DC Stmt of Variabililty.pdf SBC-00500 DC Stmt of Variabililty.pdf
Item Status:	
Status Date:	

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004-5135
Mailing Address: PO Box 34690
Seattle, WA 98124-1690
Phone 1-800-796-3872
TTY/TDD 1-800-833-6388
www.symetra.com

August 17th, 2015

To: The Insurance Commissioner

District of Columbia Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

Symetra Life Insurance Company

By: _____

Title: AVP

SUMMARY OF GENERAL PURPOSES, COVERAGE LIMITATIONS AND CONSUMER PROTECTION

General Purposes

Residents of the District of Columbia should know that licensed insurers who sell health insurance, life insurance, and annuities in the District of Columbia are members of the District of Columbia Life and Health Insurance Guaranty Association. ("Guaranty Association")

The purpose of the Guaranty Association is to assure that policy or contract holders of certain types of insurance policies and contracts are covered up to the statutory levels of protection of contractual benefits in the unlikely event that a member insurer is unable to meet its financial obligations and found by a court of law to be insolvent. When a member company is found by a court to be insolvent , the Guaranty Association will assess its other member insurers to provide benefits on any outstanding covered claims of persons who live in the District of Columbia. However, this additional protection provided through the Guaranty Association is subjected to certain statutory limitsexplained under "Coverage Limitations" section below. In some cases, the Guaranty Association may facilitate the reassignment of polices or contracts to other licensed insurance companies to keep them in-force, with not change in contractual rights or benefits.

Coverage

The District of Columbia Life and Health Insurance Guaranty Assocation ("Guaranty Assocation"), established pursuant to the Life and Health Guaranty Association Act of 1992 ("Act"), effective July 22, 1992 (D.C. Law 9-129; D.C. Official Code § 31-5401 et seq.), provides insolvency protection for certain types of insurance policies and contracts. NOTE: Certain policies and contracts may not be covered or fully covered.

The insolvency protections provided by the Guaranty Association are generally conditioned on an individual being a resident of the District and are insured under a health insurance, life insurance, or annuity contract issued by a member insurer, or they are insured under a group insurance contract issued by a member insurer. Beneficiaries, payees or assignees of District insureds are also covered under the Act, even if they live in another state.

Coverage Limitations

The Act also limits the amount the Guaranty Association is obligated to pay. The benefits for which the Guaranty Association may become liable shall be limited to the lesser of:

- The contractual obligations for which the insurer is liable or for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
- With respect to any one life, regardless of the number of policies, contracts, or certificates:
  - $300,000 in life insurance death benefits for any one life, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 in the present value of structured settlement annuity benefits, including net cash surrender or net cash withdrawal values;
  - $300,000 for long-term insurance care benefits;
  - $300,000 for disability insurance;
  - $500,000 for basic hospital, medical, and surgical insurance, or major medical insurance;
  - $100,000 for coverage not defined as disability insurance or basic hospital, medical and surgical insurance or major medical insurance or long term care insurance including any net cash surrender and net cash withdrawal values.

In no event is the Guaranty Association liable for more than $300,000 with respect to any one life ($500,000 in the event of basic hospital, medical, and surgical, and major medical claims).

Additionally, the Guaranty Association is not obligated to cover more than $5,000,000 for multiple non-group policies of life insurance with one owner regardless of the number of policies owned.

Exclusions Examples

Policy or contract holders are not protected by this Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was domiciled in a state whose guaranty association law protects insureds who live outside of that state);
- Their insurer was not authorized to do business in the District of Columbia; or
- Their policy was issued by a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, a non-profit hospital or medical service organization, a health maintenance organization, or a risk retention group.

The Guaranty Association also does not cover:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Any plan or program of an employer or association that provides life, health, or annuity benefits to its employees or members and is self-funded;
- Interest rate guarantees which exceed certain statutory limitations;
- Dividends, experience rating credits, or fees for services in connection with a policy;
- Credits given in connection with the administration of a policy by a group contract holder; or
- Unallocated annuity contracts.

Consumer Protection

To learn more about the above referenced protections, please visit the Guaranty Association's website at www.dclifega.org. Additional questions may be directed to The District of Columbia Department of Insurance, Securities and Banking (DISB) will respond to questions not specifically addressed in this disclosure document.

Policy or contract holders with additional questions may contact either:

District of Columbia
Department of Insurance, Securities, and Banking
810 First Street, N.E.,Suite 701
Washington, DC 20002
(202) 727-8000

District of Columbia
Life and Health Guaranty Association

1200 G Street, N.W.
Washington, DC 20005
(202) 434-8771

Pursuant to the Act (D.C. Official Code § 31-5416), insurers are required to provide notice to policy and contract holders of the existence of the Guaranty Association and statutory coverage protections. Your insurer and agent are prohibited by law from using the existence of the Guaranty Association and the protection it provides to market insurance products. You should not rely on insolvency protection provided under the Act when selecting an insurer or insurance product. If you have obtained this document from an agent in connection with the purchase of a policy or contract, you should be aware that such delivery does not guarantee that the Guaranty Association would cover your policy or contract. Any determination of whether a policy or contract will be covered will be determined solely by the coverage provisions of the Act.

This disclosure is intended to summarize the general purpose of the Act and does not address all the provisions of the Act. Moreover, this disclosure is not intended and should not be relied upon to alter any right established in any policy or contract, or under the Act.

READABILITY CERTIFICATION

I hereby certify on behalf of Symetra Life Insurance Company that the attached form (SBC–00500 08/12) 1/15) meets the minimum reading ease score established by the laws of your State. The test, applied to the entire form combined, achieves a Flesch score of 40.2.

Michael Fry
Executive Vice President

STATEMENT OF VARIABILITY

Variables that apply to specific text of all submitted forms

The following explains the intent behind text marked as variable by brackets [ ]. Text that is bracketed with no explanation of any alternative language, including entire pages that may be bracketed, designates that the language is either "in" or "out" of the contract, as is. If there is more than one variation of a particular provision or benefit, only the appropriate provision or benefit will be included in the issued policy/certificate/rider.

Select Benefits Contract Forms:

SBC–00535–CERT/DC 04/14 .. Certificate Form
SBC–00535–SCH 04/14..... Certificate Form
SBC–00535–DEF/DC 04/14..... Certificate Form
SBC–00535–ELI/DC 04/14..... Certificate Form
SBC–00535–BEN 04/14..... Certificate Form
SBC–00535–EXC/DC 04/14..... Certificate Form
SBC–00535–GEN/DC 04/14 .... Certificate Form

Variables that apply, in general, to all submitted forms	
Filed text may be included or omitted or transferred to another page and the document format and/or pagination may vary according to the specifications of an eligible group. Provisions and statements that are not applicable to an eligible group's policy may be omitted.	
Page numbers	
Headings may be added for clarification of an eligible group's policy. For example, class information may be added for multiple benefit offerings.	
Symetra-specific information, such as its logo and/or address, may change. Information specific to any of Symetra's affiliated or associated companies providing administrative services may also change.	
The term [Select Benefits] may be included, omitted, or modified to reflect any other name the company may use to identify its product line.	
References, throughout the document, to the following terms may vary as shown.	
[Eligible Group]	Based on the category of the eligible group, the term may be replaced with Employer, Association, Union, Participating Employer, Participating Association, Member of the Association, Member of the Union, or any other term consistent with any law or regulation of the state.
[Employee]	Based on the category of the eligible group, the term may be replaced with: Member; Association Member; Employee of the Member Association (or Association Member Employee), Union Member; Individual/Owner Proprietor; Association Employee; Independent Contractor under exclusive contract with a Participating Employer
[Schedule of Benefits]	May be replaced with Summary of Benefits
The terms monthly, weekly, and bi-weekly are interchangeable.	
All text referencing dependent(s) may be included or omitted based on the coverage and eligibility requirements elected by an eligible group	
All text referencing Prior Coverage may be included or omitted based on whether an eligible group previously had coverage	
Any title of specific acts/laws may change if the title of the law/act is changed by law.	
Additional variations, not shown in the enclosed policy/certificate/rider forms, may be agreed upon as a result of negotiations with an eligible group. However, we will not agree to any provision which is, to the best of our knowledge and belief, ambiguous or unclear, or inconsistent with any law or regulation of the state or federal government. Any changes made in such items will be determined based on sound actuarial practice and administered in a uniform and non-discriminatory manner. However, any variation to filed and approved text that is not included in the submitted forms will be filed for approval before use.	

Variables that apply to specific text of all submitted forms (continued)
The following explains the intent behind text marked as variable by brackets [ ]. Text that is bracketed with no explanation of any alternative language, including entire pages that may be bracketed, designates that the language is either "in" or "out" of the contract, as is. If there is more than one variation of a particular provision or benefit, only the appropriate provision or benefit will be included in the issued policy/certificate/rider.

Variables that apply, in general, to all submitted forms
The attached policy/certificate/rider forms are submitted in 10 point type on 8 1/2 by 11 pages. We may print the same text in a booklet format (5 1/2 by 8 1/2 pages), if requested by an eligible group. Final printed forms will be issued in at least 10 point type.
At some time in the future, it may be necessary for us to change the format, fonts, page breaks, etc. in these forms in order to accommodate new technology or new printing equipment. We reserve the right to make these types of changes without re-filing as long as there is no change in the text of these forms. However, any such accommodation will not result in the use of a font or type style or size which would violate any law, regulation or standard
Refer to State Exceptions We may convert the forms into a foreign language, based on a direct translation of the filed wording.

SBC–00535–CERT/DC 04/14	
Certificate of Coverage	
Name (Policyholder and/or Eligible Group)	Variable to display the legal name of the policyholder, an eligible group, or both
Master Policy Number	References to master policy number, master policy effective date, and eligible group along with their respective fields may be included or omitted, depending on the category of the eligible group. For example, when the policy is issued to a trust or trustee, these references will be included. When the policy is issued directly to the eligible group, the references will be omitted.
Master Policy Effective Date	
Eligible Group	
Policy Number	Variable to display the unique specifications applicable to each eligible group
Effective Date of Coverage	
Policy Anniversary	
Disclaimer Notice	Include this notice if the master policy is issued outside of North Carolina but covers residents of North Carolina
Certificate Table of Contents	
Variable to adjust contents/page numbers to the appropriate provisions for the benefits selected by an eligible group	

SBC–00535–SCH 04/14	
Summary of Benefits	
The entire section is variable to provide an eligible group with the flexibility to custom design the features of its group coverage.	
Descriptions related to eligibility/enrollment (i.e., Eligible Class; Service Waiting Period; Annual Enrollment) may vary based on the needs of the eligible group. The text shown illustrates common variations in the descriptions.	
Benefit Waiting Period	The [30 days] may decrease or be expressed using a different frequency.
Any of the benefits may be included or omitted. The benefit amounts and/or maximums for any included benefits may vary based up the eligible group's specifications. The ages shown as variable may increase. Benefit reduction percentages may decrease.	

Variables that apply to specific text of all submitted forms (continued)

The following explains the intent behind text marked as variable by brackets [ ]. Text that is bracketed with no explanation of any alternative language, including entire pages that may be bracketed, designates that the language is either "in" or "out" of the contract, as is. If there is more than one variation of a particular provision or benefit, only the appropriate provision or benefit will be included in the issued policy/certificate/rider.

SBC–00535–DEF/DC 04/14	
Definitions	
Any definition may be included or omitted depending on the coverage elected by the eligible group.	
Definitions	
Dependent	Civil union and domestic partners may be included or omitted based upon the discretion of an eligible group. The limiting age may increase.
Definitions	
Employee	Any one or all of descriptions (a)-(c) may be included

SBC–00535–ELI/DC 04/14	
Eligibility	
Eligible [Employees] & Date You Are Eligible for Coverage	Eligibility is bracketed to allow an eligible group to define its: • Conditions for eligibility • Details of any service waiting period • Time frame (e.g., first day of the month following) for coverage to take effect that best suits the group's need (e.g., to align with other coverage; payroll records)
Enrollment	The benefit enrollment rules may vary based on Symetra's underwriting guidelines, the eligible group's human resource practices, or federal IRS guidelines. The [30 days] may increase or be expressed using a different frequency.
Life Event Changes:	Text may vary based on changes in Symetra's underwriting guidelines, the eligible group's human resource practices, or federal IRS guidelines. References to domestic partners may be included or omitted based upon the discretion of an eligible group.
Evidence of insurability:	Provision may be included or omitted based on Symetra's underwriting practice for the benefits offered. When included, the text for item (a) will vary to coordinate with the group's enrollment rules.
Effective Date of Your Coverage	The text may vary to coordinate with the eligibility, enrollment and evidence rules applicable to the group.
Eligible Dependents& Date a Dependent is Eligible for Coverage	References to domestic partners may be included or omitted based upon the discretion of an eligible group. The time frame (e.g., first day of the month following) for coverage to take effect varies based on the definition that best suits the group's need (e.g., to align with other coverage; payroll records)
Enrollment	The benefit enrollment rules may vary based on Symetra's underwriting guidelines, the eligible group's human resource practices, or federal IRS guidelines. The [30 days] may increase or be expressed using a different frequency.
Life Event Changes:	Text may vary based on changes in Symetra's underwriting guidelines, the eligible group's human resource practices, or federal IRS guidelines
Evidence of insurability:	Provision may be included or omitted based on Symetra's underwriting practice for the benefits offered. When included, the text for item (a) will vary to coordinate with the group's enrollment rules.

Variables that apply to specific text of all submitted forms (continued)

The following explains the intent behind text marked as variable by brackets [ ]. Text that is bracketed with no explanation of any alternative language, including entire pages that may be bracketed, designates that the language is either "in" or "out" of the contract, as is. If there is more than one variation of a particular provision or benefit, only the appropriate provision or benefit will be included in the issued policy/certificate/rider.

SBC–00535–ELI/DC 04/14	
Change in Amounts of Benefits	Text may vary based on an eligible group's defined eligibility criteria, selected benefit offerings and contribution rules.
Change in Amounts of Coverage	Text may vary based on an eligible group's defined eligibility criteria, selected benefit offerings, contribution rules and any evidence requirements.
Termination of Your Coverage	Any one or all of the events that trigger termination may be included or omitted based on an eligible group's specifications.
Termination of Dependent Coverage	The [31 days] time frame for submitting proof of disability may be extended or be expressed using a different frequency, such as "one month."
Continuation of Coverage	Any of the continuation periods, [6 months], [2 months], may be extended or be expressed using a different frequency, such as "60 days." The entire section may be omitted when the covered group's eligibility isn't related to employment.
Reinstatement	The [90 days] reinstatement period may be extended or be expressed using a different frequency, such as "three months." The effective date time frame will vary to best suit the needs of the eligible group (e.g., to align with other coverage; payroll records).

SBC–00535–BEN 04/14	
Critical Illness Benefit	
	The provision [Your employment ceases for any reason]" if the plan allows for incremental choices of coverage. Otherwise, us "[the benefit amount]". Category 1, Category 2, Category 3 or Category 4 may be included or excluded, based on policyholder request. The term "Schedule of Benefits" may vary to reflect another name such as "Benefits Schedule" or some similar term. The term "or increase in benefit" is included if the plan includes incremental benefit amounts. Include if Category 1, 2, 3 or 4 is included in the plan. Remove any Categories which are not included. Include if the plan includes a recurrence benefit. The term "Employee" may be replaced by a similar term such as member or associate. The standard recurrence time is 18 months. If chosen, the recurrence time period may vary for "the same category" to be different than recurrence for "another category" and may be limited to 100% of the benefit amount minus any previous benefits paid.
Covered Critical Illness Descriptions	
Invasive Cancer	In or out, depending on Category(ies) included in the plan.
Minor Cancer	In or out, depending on Category(ies) included in the plan.

Variables that apply to specific text of all submitted forms (continued)

The following explains the intent behind text marked as variable by brackets [ ]. Text that is bracketed with no explanation of any alternative language, including entire pages that may be bracketed, designates that the language is either "in" or "out" of the contract, as is. If there is more than one variation of a particular provision or benefit, only the appropriate provision or benefit will be included in the issued policy/certificate/rider.

SBC–00535–BEN 04/14	
Heart Attack (Myocardial Infarction)	In or out, depending on Category(ies) included in the plan. The variable text [coronary artery disease, hypertension, dissection or similar disease] may change to add, omit, or adjust a named disease or omit the phrase "or similar disease" in order to keep up to date with current medical science and terminology as well as to base coverage on the specifications of an eligible group and Symetra's underwriting guidelines.
Stroke	In or out, depending on Category(ies) included in the plan. The variable text [athlerothrombosis, cardioembolic disease or hypertension or similar disease] may change to add, omit, or adjust a named disease or omit the phrase "or similar disease" in order to keep up to date with current medical science and terminology as well as to base coverage on the specifications of an eligible group and Symetra's underwriting guidelines.
Coronary Artery Disease Needing Surgery or Angioplasty	In or out, depending on Category(ies) included in the plan
Coma Due to Accident	In or out, depending on Category(ies) included in the plan
Occupational Human Immunodeficiency Virus (HIV) Infection Due to Accident	In or out, depending on Category(ies) included in the plan
Loss of Sight	In or out, depending on Category(ies) included in the plan. The variable text [cataracts, glaucoma, or macular degeneration or similar disease] may change to add, omit, or adjust a named disease or omit the phrase "or similar disease" in order to keep up to date with current medical science and terminology as well as to base coverage on the specifications of an eligible group and Symetra's underwriting guidelines.
Loss of Speech	In or out, depending on Category(ies) included in the plan. The variable text [Guillain Barre syndrome or Huntington's disease chorea or similar disease] may change to add, omit, or adjust a named disease or omit the phrase "or similar disease" in order to keep up to date with current medical science and terminology as well as to base coverage on the specifications of an eligible group and Symetra's underwriting guidelines.
Loss of Hearing	In or out, depending on Category(ies) included in the plan. The variable text [bacterial meningitis or Meniere's disease or similar disease] may change to add, omit, or adjust a named disease or omit the phrase "or similar disease" in order to keep up to date with current medical science and terminology as well as to base coverage on the specifications of an eligible group and Symetra's underwriting guidelines.
Major Organ Failure	In or out, depending on Category(ies) included in the plan. The variable text [Hypertensive Nephropathy, Cardiomyopathy or Cirrhosis or similar disease] may change to add, omit, or adjust a named disease or omit the phrase "or similar disease" in order to keep up to date with current medical science and terminology as well as to base coverage on the specifications of an eligible group and Symetra's underwriting guidelines.
End Stage Renal Failure	In or out, depending on Category(ies) included in the plan
Paralysis due to Accident	In or out, depending on Category(ies) included in the plan
Severe Burns	In or out, depending on Category(ies) included in the plan

Variables that apply to specific text of all submitted forms (continued)

The following explains the intent behind text marked as variable by brackets [ ]. Text that is bracketed with no explanation of any alternative language, including entire pages that may be bracketed, designates that the language is either "in" or "out" of the contract, as is. If there is more than one variation of a particular provision or benefit, only the appropriate provision or benefit will be included in the issued policy/certificate/rider.

SBC–00535–BEN 04/14	
Advanced Alzheimer's Disease	In or out, depending on Category(ies) included in the plan
Multiple Sclerosis	In or out, depending on Category(ies) included in the plan
Parkinson's Disease	In or out, depending on Category(ies) included in the plan
Amyotrophic Lateral Sclerosis (ALS) and other Motor Neuron Diseases	In or out, depending on Category(ies) included in the plan
Recurrence Benefit	
Include in its entirety if the plan includes a Recurrence Benefit. "Schedule of Benefits" may vary to reflect another name such as "Benefits Schedule" or some similar term.	
Health Screening Benefit	
Include references to "spouse" and dependent child if the plan includes coverage for either or both. If no spouse or dependent child coverage remove the bracketed items.	

SBC–00535–GEN/DC 04/14
Notice of Claim
The first paragraph may vary to only include the notice wording applicable to the benefits selected by an eligible group. The time frames [20 days], [90 days] may be modified or be expressed using a different frequency, such as "three months." Any change to a time frame will be consistent with any law or regulation of the state.
Claim Forms
The time frames [15 days] may be modified or be expressed using a different frequency, such as "two weeks." Any change to a time frame will be consistent with any law or regulation of the state.
Proof of Loss
The first and third paragraphs may vary to only include the wording applicable to the benefits selected by an eligible group. The time frames [90 days], [one year] may be modified or be expressed using a different frequency, such as "12 months." Any change to a time frame will be consistent with any law or regulation of the state.
Time Payment of Claims
The time frame [30 days] may be modified or be expressed using a different frequency, such as "one month." Any change to a time frame will be consistent with any law or regulation of the state. The second paragraph may be omitted if an eligible group did not select disability benefits.
Payment of Benefits
The second paragraph may be omitted if an eligible group did not select life or accidental death benefits.
Extension of Coverage
The entire section may be omitted when the covered group's eligibility isn't related to employment.

STATEMENT OF VARIABILITY

Variables that apply to specific text of all submitted forms

The following explains the intent behind text marked as variable by brackets [ ]. Text that is bracketed with no explanation of any alternative language, including entire pages that may be bracketed, designates that the language is either "in" or "out" of the contract, as is. If there is more than one variation of a particular provision or benefit, only the appropriate provision or benefit will be included in the issued policy/certificate/rider.

Select Benefits Contract Forms:

SBC–00500/DC 8/12 ..... Policy Form

Variables that apply, in general, to all submitted forms	
Filed text may be included or omitted or transferred to another page and the document format and/or pagination may vary according to the specifications of an eligible group. Provisions and statements that are not applicable to an eligible group's policy may be omitted.	
Headings may be added for clarification of an eligible group's policy. For example, class information may be added for multiple benefit offerings.	
Symetra-specific information, such as its logo and/or address, may change. Information specific to any of Symetra's affiliated or associated companies providing administrative services may also change.	
The term [Select Benefits] may be included, omitted, or modified to reflect any other name the company may use to identify its product line.	
References, throughout the document, to the following terms may vary as shown.	
[Eligible Group]	Based on the category of the eligible group, the term may be replaced with Employer, Association, Union, Participating Employer, Participating Association, Member of the Association, Member of the Union, or any other term consistent with any law or regulation of the state.
[Employee]	Based on the category of the eligible group, the term may be replaced with: Member; Association Member; Employee of the Member Association (or Association Member Employee), Union Member; Individual/Owner Proprietor; Association Employee; Independent Contractor under exclusive contract with a Participating Employer
[Schedule of Benefits]	May be replaced with Summary of Benefits
The terms monthly, weekly, and bi-weekly are interchangeable.	
All text referencing dependent(s) may be included or omitted based on the coverage and eligibility requirements elected by an eligible group	
All text referencing Prior Coverage may be included or omitted based on whether an eligible group previously had coverage	
Any title of specific acts/laws may change if the title of the law/act is changed by law.	
Refer to State Exceptions Additional variations, not shown in the enclosed policy/certificate/rider forms, may be agreed upon as a result of negotiations with an eligible group. However, we will not agree to any provision which is, to the best of our knowledge and belief, ambiguous or unclear, or inconsistent with any law or regulation of the state or federal government. Any changes made in such items will be determined based on sound actuarial practice and administered in a uniform and non-discriminatory manner. OR Any variation to filed and approved text that is not included in the submitted forms will be filed for approval before use.	
The attached policy/certificate/rider forms are submitted in 10 point type on 8 1/2 by 11 pages. We may print the same text in a booklet format (5 1/2 by 8 1/2 pages), if requested by an eligible group. Final printed forms will be issued in at least 10 point type.	

Variables that apply to specific text of all submitted forms (continued)
The following explains the intent behind text marked as variable by brackets [ ]. Text that is bracketed with no explanation of any alternative language, including entire pages that may be bracketed, designates that the language is either "in" or "out" of the contract, as is. If there is more than one variation of a particular provision or benefit, only the appropriate provision or benefit will be included in the issued policy/certificate/rider.

Variables that apply, in general, to all submitted forms
At some time in the future, it may be necessary for us to change the format, fonts, page breaks, etc. in these forms in order to accommodate new technology or new printing equipment. We reserve the right to make these types of changes without re-filing as long as there is no change in the text of these forms. However, any such accommodation will not result in the use of a font or type style or size which would violate any law, regulation or standard
Refer to State Exceptions We may convert the forms into a foreign language, based on a direct translation of the filed wording.

SBC–00500/DC 8/12	
Policy Cover; Policy Introduction	
Policy Name	The appropriate name identifying the type of coverage for which the policy is issued will be reflected.
Notice	The Notice may be included or omitted depending on the type of coverage for which the policy is issued. When included, it will appear on either the cover page, the Introduction page or both.
	Illustrative text is shown for a Fixed-Payment Indemnity policy. The phrase [and other] may be included or omitted, depending on covered benefits. For example, the phrase may be included when non-medical benefits such as Disability Income or Life Insurance benefits are included under the policy.
Policy Specifications	
Policyholder	Variable to display the policyholder's legal name
Master Policy Number	References to master policy number, master policy effective date, and eligible group along with their respective fields may be included or omitted, depending on the category of the eligible group. For example, when the policy is issued to a trust or trustee, these references will be included. When the policy is issued directly to the eligible group, the references will be omitted.
Master Policy Effective Date	
Eligible Group	
Policy Number	Variable to display the unique specifications applicable to each policy that is issued
Policy Effective Date	
Premium Due Date	
Policy Anniversary	
Governing Jurisdiction	
The phrase [the application of the Eligible Group] may be included or omitted, depending on the category of the eligible group. For example, when the policy is issued to a trust or trustee, the phrase will be included. When the policy is issued directly to the eligible group, the phrase will be omitted.	
Information in the final two paragraphs/signatures may vary based on any change to the titles/names of the Symetra parties authorized to execute the policy. The reference to [Master] may be included or omitted, depending on the category of the eligible group.	
Eligible Group Section	
Eligible Group Name	Variable to display the unique specifications applicable to each eligible group

Variables that apply to specific text of all submitted forms (continued)

The following explains the intent behind text marked as variable by brackets [ ]. Text that is bracketed with no explanation of any alternative language, including entire pages that may be bracketed, designates that the language is either "in" or "out" of the contract, as is. If there is more than one variation of a particular provision or benefit, only the appropriate provision or benefit will be included in the issued policy/certificate/rider.

SBC–00500/DC 8/12	
Policy Number	
Effective Date of Coverage	
Policy Contents	
Variable to display the contents/page numbers appropriate for each policy issued	
Schedule of Premium Rates	
Initial Rate	The entire section is marked as variable to accommodate the pricing of various combinations of coverage selected by an eligible group. For example, a monthly rate may be shown for employee-only coverage, employee & spouse coverage, or family coverage. In addition, the rate may be expressed using a different payment frequency, such as hourly or quarterly.
Rate Guarantee	The guarantee period of [12 months] may be extended or be expressed using a different frequency, such as "one year." The bracketed percentage may increase. The notice time frame [31 days] may be extended or be expressed using a different frequency, such as "one month."
Associated Entities	
The entire section may be included or omitted depending on the eligible group	
Name	These fields are variable to show the detail applicable to each entity.
Effective Date	
Termination Date	
Eligible Group Provisions	
Entire Contract	The phrase [the application of the Eligible Group] may be included or omitted, depending on the category of the eligible group. For example, when the policy is issued to a trust or trustee, the phrase will be included. When the policy is issued directly to the eligible group, the phrase will be omitted.
Eligible Group Provisions	
Incontestability of Policy	The incontestability period [two years] may be extended for either the eligible group, the insured or both
Payment of Premiums	The frequency [monthly] may vary to accommodate an eligible group's needs
Grace Period	The grace period of [31 days] may be extended, or varied to express an equivalent monthly or weekly time period.
Eligible Group Provisions (Continued)	
Change in Premium Rates	The notice time frame [31 days] may be extended or be expressed using a different frequency, such as "one month."
Premium Adjustment	The [3-month] time period may be extended, or varied to express an equivalent daily, weekly or yearly time period.
Termination by the [Eligible Group	Any of the notice time frames shown: [31 days]; [45 days]; [10 days]; [12 months]; [45 days]; [20 days], may be extended or be expressed using a different frequency.

STATEMENT OF VARIABILITY

Variables that apply to specific text of all submitted forms (continued)

The following explains the intent behind text marked as variable by brackets [ ]. Text that is bracketed with no explanation of any alternative language, including entire pages that may be bracketed, designates that the language is either "in" or "out" of the contract, as is. If there is more than one variation of a particular provision or benefit, only the appropriate provision or benefit will be included in the issued policy/certificate/rider.

SBC–00500/DC 8/12	
Termination by Symetra	
Renewal	